State of Wisconsin
Department of Workforce Development
Equal Rights Division

ER Case #:
CR
For ERD Use Only

Retaliation Complaint
Elder Abuse/Health Care Worker Laws

Personal information you provide may be used for secondary purposes (s. 15.04(1)(m), Wisconsin Statutes).

Authorization for this form is provided under Section 111.39(1), Wisconsin Statutes.

Completion of this form is voluntary. However, if you wish to file a complaint of retaliation with the Equal Rights Division (ERD), you must submit a written document containing the information sought by this form.

THESE RETALIATION LAWS ARE Sections 16.009, 46.90, 50.07 55.043 and 146.997, Wisconsin Statutes. Each law has different retaliation protections. The Equal Rights Division will match your complaint with the laws. The division will notify you and the Respondent of the applicable laws. You will have an opportunity to inform the division if you disagree.

Instructions -- Please Read Before Completing This Form

Provide all information requested below. **TYPE OR PRINT IN BLACK INK.** You must sign this complaint **on page 2**, and fill out the Process Information Sheet on **page 3** before submitting your complaint to the Equal Rights Division.

1. Complainant Information

First Name	Middle Initial	
Last Name		
Street Address		
City	State	Zip Code
Telephone Number		
Email Address		
County in Wisconsin where you worked: Select County		

2. Respondent Information

The Respondent is the **company**, agency, or union you believe discriminated against you. Name only one Respondent per form. Do **not** name an **individual person** as Respondent.		
Name		
Street Address		
City	State	Zip Code
Telephone Number Ext.		
What type of business is the Respondent?		
Describe the Respondent residents or patients:		
Age: ☐ Under 60 ☐ Over 60 ☐ Both		
Persons with Disabilities: ☐ Yes ☐ No		
Other:		

3. What did you do that you believe is protected by law?

(For example: “complained about abuse or neglect of patients or residents” or “reported understaffing” or "objected to a standard of care issue" etc.) Give the date of each action (month/day/year).
If you did not do anything, skip to question #5.

4. If you answered question 3, did you talk, write or send an email to someone?

☐ Yes ☐ No

If No, skip to question 5.

If Yes, give the name, title and telephone number of the person you contacted.
(For example: “Jane Doe, state ombudsman" or "John Forest, my supervisor”, etc.). Give the date of each action. What exactly did you say?

5. If you did not answer question 3 or answered No to question 4:

What action do you believe your employer thought you had taken or would take? Give approximate date when you believe your employer started thinking that. Give the name and title of the person who believed that. (For example: “Jane Doe, my supervisor” or “Pat Meadow, the Director of Nursing” or “Bill Maple, the Administrator”, etc.

6. Describe the employment action(s) your employer took because of what you did or because of what they thought you did or you would do.

(For example: terminated me, disciplined me, demoted me, reduced my hours, etc.). If your employer took more than four employment actions, please describe on a separate sheet of paper and attach to this form.

a. First employment action: Date taken:
b. Second employment action: Date taken:
c. Third employment action: Date taken:
d. Fourth employment action: Date taken:

7. Certification and Signature

By my signature below, I certify that I have read the above complaint, and, under penalties of law, I declare that this complaint is true and correct to the best of my knowledge and belief.

Complaint or Complainant Representative Signature	Date Signed

Mail your completed and signed complaint form to one of the following addresses:

Equal Rights Division
201 E Washington Ave., Room A400
PO Box 8928
Madison WI 53708

Telephone: (608) 266-6860
Fax: (608) 267-4592

Equal Rights Division
819 N 6th ST
Room 723
Milwaukee WI 53203

Telephone: (414) 227-4384
Fax: (414) 227-4084

Equal Rights Complaint Process Information Sheet

Please complete and return this sheet with your complaint. This information is necessary to process your complaint effectively.

Complainant First Name	Complainant Middle Initial	Complainant Last Name

Current Date	Complainant Date of Birth (requested for identification purposes) mm/dd/yyyy

If your job requires you to have a License or Certification (i.e. EMT, 1st Responder) please indicate what it is.
If not required, leave blank.

Contact Information (Important! The Complainant must notify the Equal Rights Division, if there is a change of address or telephone number. If we are unable to locate the Complainant, the complaint may be dismissed).

Is there a telephone number where the Complainant can be reached between 7:45 a.m. & 4:30 p.m.? ☐ Yes ☐ No	If Yes, provide the area code and telephone number

Please provide the name, address, and telephone number of someone who does not reside with the Complainant but who will know where to reach the Complainant.

Contact Person Name	Relationship to the Complainant			
Street Address	City	State	Zip Code	Telephone Number

Employer Information

Approximate number of employees at all of the employer's work locations ☐ Less than 50 ☐ 50-100 ☐ 101-200 ☐ 201-500 ☐ More than 500	Type of Business
Does another company own the employer? ☐ Yes ☐ No ☐ Not Sure	If Yes, please provide the name of that company

Filing With other Agencies

Have you filed a complaint in this matter with any other agency? ☐ Yes ☐ No	If Yes, name of agency	Date filed with the other agency

Settlement Information

At this time, what is the Complainant seeking to settle the complaint?

Complete this section if the Complainant was or still is employed by the employer

When was the Complainant hired?	What was/is the job title?	Is the Complainant still employed by the Respondent? ☐ Yes ☐ No

Complete this section if the Complainant is no longer employed by the employer

How did the Complainant's employment end? ☐ Discharged ☐ Quit ☐ Laid off ☐ Retired ☐ Other	Date Employment Ended	Pay Rate at End	Hours per Week

If the Complainant was not promoted, what was the title of the position applied for?	Rate of Pay	Hours per Week

Statistical Information

Complainant Sex
☐ Male ☐ Female

Complainant Race (check appropriate box or boxes):
☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Black or African American
☐ Asian ☐ White ☐ Other