

**COMPLAINT FORM**

**(Formulaire disponible en français)**

**Case #**

Please complete this form and send it to us either by fax at 1-(506)-453-3806 or by mail at The Department of Post-Secondary Education, Training and Labour, Employment Standards Branch, P.O. Box 6000, Fredericton, N.B., E3B 5H1

**Section A INFORMATION ABOUT YOU**

<input type="text"/>		<input type="text"/>	
Last Name		First or Given Name	
<input type="text"/>		<input type="text"/>	<input type="text"/>
Mailing Address		Place and Province	Postal Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home Phone no.	Other Phone no.	Fax no.	E-Mail
May we release your name to your employer?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Initial _____	

**Section B INFORMATION ABOUT YOUR EMPLOYER**

<input type="text"/>		<input type="text"/>	
Name of Employer, Company or Business		Type of Business	
<input type="text"/>		<input type="text"/>	<input type="text"/>
Employer's Mailing Address		Place and Province	Postal Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of Contact person	Contact type	Business Phone no.	Other Phone no.
		Fax no.	

**Section C YOUR WORK HISTORY WITH THIS EMPLOYER**

<input type="text"/>		<input type="text"/>	<input type="text"/>
Occupation		Employed from	Employed to
<input type="checkbox"/> Still Employed	<input type="checkbox"/> Quit	<input type="checkbox"/> Fired	<input type="checkbox"/> Laid Off

**\$**

Pay Rate (Please specify, Hourly, Salary, Commission, Bonus, etc.)

<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly
Pay Period				

**For office use only**

<input type="text"/>	<input type="text"/>	<input type="checkbox"/> E-Mail	<input type="checkbox"/> Fax	<input type="checkbox"/> Letter	<input type="checkbox"/> Phone	<input type="checkbox"/> Walk-in
Filed Date	Taken by	Please specify				
<input type="text"/>	<input type="text"/>	<b>STAMP DATE</b>				
Assigned to	Assigned on					

**SECTION D NATURE OF COMPLAINT**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Termination Pay                        | <input type="checkbox"/> Minimum Wage                 | <input type="checkbox"/> Weekly Rest Period |
| <input type="checkbox"/> Notice of Termination / Pay in lieu of | <input type="checkbox"/> Minimum Overtime             | <input type="checkbox"/> Sunday Work        |
| <input type="checkbox"/> Vacation                               | <input type="checkbox"/> Maternity / Child Care Leave | <input type="checkbox"/> Rules of payment   |
| <input type="checkbox"/> Paid Public Holiday                    | <input type="checkbox"/> Sick Leave                   | <input type="checkbox"/> Other (specify)    |
| <input type="checkbox"/> Unauthorized Deductions                | <input type="checkbox"/> Family Responsibility Leave  | _____                                       |

**SECTION E DETAILS OF COMPLAINT**

Was this complaint discussed with your employer?  Yes  No    If yes, please add details in your statement below.

In your own words provide below a brief yet precise statement of your complaint. Use additional sheets if necessary.

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Do you have relevant information to support your complaint?  Yes  No

If yes, please include photocopies.  
Example; Record of Employment, pay stubs, correspondence, contract of employment, working conditions, etc.

Are you covered by a collective agreement?  Yes  No

If yes, which union:  
If yes, have you attempted to grieve this matter?

Representative name:

*I certify that all information provided is true and correct to the best of my knowledge.*

Signature of Complainant \_\_\_\_\_ Date \_\_\_\_\_