



State of New Jersey
Department of Labor and Workforce Development
Office of Special Compensation Funds
 P O Box 399
 Trenton, New Jersey 08625-0399

<p>COMPLAINT OF DISCRIMINATION <u>N.J.S.A. 34:15-39.1 et seq.</u></p>

The New Jersey Workers' Compensation Law (N.J.S.A. 34:15-1 et seq.) provides that it shall be unlawful for an employer to discharge or otherwise discriminate against an employee because that employee has filed or has attempted to file a claim for workers' compensation benefits or has testified or has planned to testify in any proceeding before the Division of Workers' Compensation. This complaint is to be completed by an employee who alleges such discrimination.

01. Your Name: <i>(Last) (First) (Middle)</i>	02. Your Social Security Number:
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03. Your complete home address: <i>(Street Number - No PO Boxes) (City) (County) (State) (Zip Code)</i>				
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04. Your Home Telephone Number:	05. If Employed, your Daytime Telephone Number:
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06. Nature of Complaint <i>(Check One)</i> : a. <input type="checkbox"/> I feel that I was discriminated against because of my filing or attempting to file a workers' compensation claim. b. <input type="checkbox"/> I feel that I was discriminated against because of my testimony or plans to testify in a workers' compensation proceeding.

07. Name of Employer:	08. New Jersey Employer Identification Number (if known):
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09. Complete Employer Address: <i>(Street Number - No PO Boxes) (City) (County) (State) (Zip Code)</i>				
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10. Employer Agent Name:	11. Employer Agent Telephone:
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COMPLETE ITEMS #12 THROUGH #20 ONLY IF YOU HAVE CHECKED BOX "a" IN ITEM #06, ABOVE

12. Name of Employer's Workers' Compensation Insurance Carrier:	13. Have you filed a claim with this carrier? <input type="checkbox"/> No <input type="checkbox"/> Yes, Claim #: _____
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14. Have you filed a Claim with the NJ Div. of Workers' Compensation? <input type="checkbox"/> No <input type="checkbox"/> Yes, Claim Petition #: _____	15. Date of Accident/Illness:
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16. Your Occupation at Time of Accident/Illness:	17. Nature of Your Disability:
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18. Your Gross Weekly Wages at Time of Accident/Illness: \$ _____ Per Week	17. Nature of Your Disability:
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19. Your Job Duties at Time of Accident/Illness:	20. Are You Currently Able to Perform These Duties? <i>(Check One)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
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(CONTINUED ON BACK)

(CONTINUED FROM FRONT)

COMPLETE ITEMS # 21 THROUGH #26 ONLY IF YOU HAVE CHECKED BOX "b" IN ITEM #6

21. Full Name of Petitioner in Workers' Compensation Case:	22. Claim Petition Number:
23. Did You Testify in this Case? (Check One) <input type="checkbox"/> No <input type="checkbox"/> Yes (If Yes, Complete Item #24)	24. Date and Location of Testimony:
25. Are You Scheduled to Testify in this Case? (Check One) <input type="checkbox"/> No <input type="checkbox"/> Yes (If Yes, Complete Item #26)	26. Scheduled Date and Location of Testimony:

27. Date of Termination or Other Personnel Action:	29. If Currently Employed, Employer's Name and Address
28. Reason Give by Employer for Action:	
	30. If Employed, Your Current Weekly Gross Wages: \$ _____ Per Week

31. State here and/or on attached sheets, the reason(s) for your alleging discrimination:

State of New Jersey, County of _____

_____, of full age, being duly sworn according to law, on his/her oath deposes and says:
That he/she is the complainant named in the foregoing complaint; that he/she has read the same; and that the matters and thing therein set forth are true according to the best of his/her knowledge and belief.

(Complainant Signature)

Subscribed and sworn before me this _____ day of _____, _____.