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

COMPLAINT OF DISCRIMINATION

N.J.S.A. 34:15-39.1 et seq.

SCF-4 (R 05-13)

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 the employee who alleges such discrimination

Please Note: All applicable information must be completed on this complaint and any and all relevant evidence supporting the complaint must be attached. The complaint must be signed by the complainant and notarized. The complaint and attachments must be submitted in duplicate (original and one copy).

01. Your Name: *(Last) (First) (Middle)*	02. Your Social Security Number:
03. Your Complete Home Address: *(Street Number – No PO Boxes) (City) (County) (State) (Zip Code)*	
04 Your Telephone Number:	05. If Employed, Your Daytime Telephone Number:

06. Nature of Complaint: (Check One)
a. □ I feel that I was discriminated against for filing or attempting to file a workers' compensation claim.
b. □ I feel that I was discriminated against for my testimony or plan to testify in a workers' compensation matter.

07. Name of Employer:	08. New Jersey Employer Identification Number (if known):
09. Complete Employer Address: *(Street Number – No PO Boxes) (City) (County) (State) (Zip Code)*	
10. Employer Agent Name:	11. Employer Agent Telephone Number:

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? □ No □ Yes, Claim#:_____
14. Have you filed a claim with the NJ Division of Workers' Compensation? □ No □ Yes, Claim Petition#:_____	15. Date of Accident/Last Exposure:
16. Your Occupation at Time of Accident/Last Exposure:	17. Nature of Your Disability:
18. Your Gross Weekly Wages at Time of Accident/Last Exposure:	
19. You Job Duties at Time of Accident/Last Exposure:	20. Are You Currently Able To Fully Perform Those Duties? □ Yes □ No*

*If you have checked "No" for Item #20, indicating that you are not currently able to fully perform the duties of your employment, your remedies under the law are limited. While the complaint can be processed and penalties assessed against the employer, if found to have committed prohibited acts, the law provides that no reinstatement to employment or compensation for lost wages may be ordered for any period during which you are not fully able to perform the duties of your employment.

(CONTINUED ON BACK)

(CONTINUED FROM FRONT)

COMPLETE ITEMS #21 THROUGH #26 ONLY IF YOU HAVE CHECKED "b" IN ITEM #06, ABOVE	
21. Full Name of Petitioner in Workers' Compensation Case	22. Claim Petition Number:
23. Did You Testify in this Case? □ No □ Yes (*If Yes, Complete Item #24)*	24. Date and Location of Testimony:
25. Are You Scheduled to Testify in this Case? □ No □ 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 Given by Employer for Termination or Other Action:	30. If Employed, Your Current Gross Weekly Wages:

31. State here and/or attach to this complaint **any and all relevant evidence** supporting your allegation of discrimination:

State of New Jersey, County of _____

_____, of full age, being duly sworn according to law, on my oath depose and say: That I am the complainant named in the foregoing complaint; that I have read the same; and that the matter and things therein set forth are true according to the best of my knowledge and belief.

_____

(Complainant's Signature)

_____

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