Public Employees' Occupational Safety & Health Complaint

Name of Employer	Telephone Number/Email

Street Address (Mailing)

City	State	ZIP Code	County

Type (Check one)

☐ State Agency ☐ County ☐ Municipality
☐ School Board ☐ Utility Authority ☐ Other (Specify): _____

Hazard Location/Name of Building (Specify building and exact location where alleged violation exists. Use separate form for each building.	Floor and Room Number

Street Address (Site)

City	State	ZIP Code	County

Name of Person(s) in charge	Telephone Number/Email

Briefly describe your complaint

Approximate number of employees in area	Do any employees believe they have health problems related to the complaint? ☐ Yes ☐ No	Number of employees experiencing symptoms?

Type of work done in the area (for example, clerical, maintenance, firefighter)

Materials handled (chemicals, cleaning compounds, etc.)

To your knowledge, has there been a previous inspection related to the complaint?

☐ Yes Inspected by _____
☐ No

Date Inspected	Outcome of Inspection

To your knowledge, has this complaint been the subject of any union/management grievance, or have you (or anyone you know) otherwise called it to the attention of, or discussed with, the employer or any representative thereof?

☐ Yes ☐ No

If *Yes*, give the results thereof, including any efforts by management to correct violation. (Attach separate sheet if needed)

Name of Union	Local Number	Telephone Number/Email
Name of Representative	Title	

THE INFORMATION BELOW WILL REMAIN CONFIDENTIAL UPON REQUEST

Please indicate your preference:

☐ DO NOT REVEAL MY NAME ☐ MY NAME MAY BE REVEALED TO THE EMPLOYER

☐ I WANT TO BE PRESENT WHEN THE INSPECTION IS CONDUCTED.

The complainant whose signature appears below is the (check one):

☐ Employee ☐ Representative of Employees ☐ Employer ☐ Other (Specify): _____

Name of Complainant (Print or Type)	Signature (Required)	Date

Complainant Certification

☐ By selecting this check box, I am signing this form electronically. I agree my electronic signature is the legal equivalent of my manual /handwritten signature on this form. By selecting this check box using any device, means or action, I consent to the legally binding terms and conditions: N.J.A.C. 12:110-4.4(i). N.J.A.C. 12:110-4.4(i.): Whoever knowingly makes any false statements, representation or certification, verbally or in writing, in any application, record, report, plan or other document filed or required to be maintained pursuant to this chapter shall be liable for an administrative penalty pursuant to N.J.A.C. 12:110-4.11. I further agree that my signature on this document (hereafter referred to as my "E-Signature") is as valid as if I signed the document in writing.

Street Address

City	State	ZIP Code	County
Telephone Number/Email		Best Time to Contact	

IF YOU ARE AN AUTHORIZED REPRESENTATIVE OF EMPLOYEES AFFECTED BY THIS COMPLAINT, COMPLETE THE FOLLOWING:

Name of Organization	Your Organization Title

	For SAFETY-RELATED ISSUES	For HEALTH-RELATED ISSUES
MAIL COMPLETED FORM TO:	**Office of Public Employees' Occupational Safety and Health** New Jersey Department of Labor and Workforce Development PO Box 386 Trenton, New Jersey 08625-0386	**Office of Public Employees' Occupational Safety and Health** New Jersey Department of Health PO Box 369 Trenton, New Jersey 08625-0369
OR		
EMAIL COMPLETED FORM TO:	**PEOSHA@dol.nj.gov**	**PEOSH@doh.nj.gov**
OR		
FAX COMPLETED FORM TO:	**609-292-3749**	**609-984-2779**

Phone: 609-292-7036 **Hotline:** 1-800-624-1644