

State of New Jersey
ASBESTOS LICENSING & CONTROL
COMPLAINT

STATE USE ONLY	
Complaint No.	Date Rec'd
Date Closed	Investigator Code
Completed By <input type="checkbox"/> Complainant <input type="checkbox"/> Department	

1. Name of Employer	2. Telephone Number ()
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3. Street Address (Mailing)	
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4. City, State, Zip Code	5. County
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6. Type (Check one)	
<input type="checkbox"/> State Agency <input type="checkbox"/> County <input type="checkbox"/> Municipality <input type="checkbox"/> School Board <input type="checkbox"/> Utility Authority <input type="checkbox"/> Other (Specify):	

7. Hazard Location/Name of Building (Specify building and exact location where alleged violation exists. Use separate form for each building.)	8. Floor and Room Number
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9. Street Address (Site)	
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10. City, State, Zip Code	11. County
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12. Name of Person(s) in Charge	13. Telephone Number ()
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14. Briefly describe your complaint:	
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15. Approximate Number of Employees in Area	a. Are there employees who believe they have health problems related to the complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No	b. Number of employees experiencing symptoms?
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16. Type of work done in the area (i.e., clerical, maintenance, firefighter)	
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17. Materials handled (chemicals, cleaning compounds, etc.)	
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18a. To your knowledge, has there been a previous inspection related to the complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No	b. If Yes, by whom?
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c. Date Inspected	d. Outcome of Inspection
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Complaint No.

ASBESTOS LICENSING & CONTROL

COMPLAINT (Continued)

19. 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 it with, the employer or any representative thereof?

- Yes No

If Yes, give the results thereof, including any efforts by management to correct the violation.

20. Name of Union 21. Local Number
22. Name of Employee Representative 23. Telephone Number ()

24. Title

THE INFORMATION BELOW WILL REMAIN CONFIDENTIAL UPON REQUEST

25. Please indicate your desire:
DO NOT REVEAL MY NAME.

26. The complainant, whose signature appears below (check one):
Employee
Representative of Employees
Employer
Other (Specify):

27. Name of Complainant (Print or Type) 28. Signature 29. Date

30. Street Address

31. City, State, Zip 32. County

33. Telephone Number () 34. Best Time to Contact

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

35. Name of Organization

36. Your Organization Title

Mail Completed forms to: or Fax to:
NJ Department of Labor and Workforce Development
Asbestos Licensing and Control
P.O. Box 949
Trenton, New Jersey 08625-0949
(609) 635-0664