State of New Jersey

PUBLIC EMPLOYEES OCCUPATIONAL SAFETY AND HEALTH

COMPLAINT

STATE USE ONLY	
Complaint No.	Date Rec'd
Date Closed	Investigator Code
Completed By [ ] Complainant [ ] Department	

1. Name of Employer	2. Telephone Number ( )
3. Street Address (Mailing)	
4. City, State, Zip Code	5. County

6. Type (Check one)

☐ State Agency ☐ County ☐ Municipality ☐ School Board ☐ Utility Authority ☐ 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
9. Street Address (Site)	
10. City, State, Zip Code	11. County
12. Name of Person(s) in Charge	13. Telephone Number ( )

14. Briefly describe your complaint:

15. Approximate Number of Employees in Area	a. Are there employees who believe they have health problems related to the complaint? ☐ Yes ☐ No	b. Number of employees experiencing symptoms?
16. Type of work done in the area (i.e., clerical, maintenance, firefighter)		
17. Materials handled (chemicals, cleaning compounds, etc.)		
18a. To your knowledge, has there been a previous inspection related to the complaint? ☐ Yes ☐ No	b. If Yes, by whom?	
c. Date Inspected	d. Outcome of Inspection	

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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.

OR

☐ MY NAME MAY BE REVEALED TO THE EMPLOYER

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

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 (Required)	29. 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. 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.	

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