Washington
Paid Family & Medical Leave
Employment Security Department

Instructions for filing an unlawful act complaint

Complete this form to file a complaint against an employer you think has committed an unlawful act involving the Paid Family and Medical Leave program.

What is an unlawful act?

An "unlawful act" is defined in RCW 50A.40.010 and WAC 192-570-020. A finding of an unlawful act would mean the employer interfered with, restrained, or denied the ability for the employee to use Paid Family and Medical Leave. Or, that the employer discharged or discriminated against an employee for filing a complaint or engaging in proceedings related to Paid Family and Medical Leave.

Please note, you may initiate a private civil action, or you may file a complaint with the Employment Security Department, however, you may not do both per RCW 50A.40.040 and WAC 192-570-030. If you have already filed a complaint with the department and wish to initiate a private civil action, you must first withdraw your complaint with the department.

What will the department do with a complaint?

The department will conduct an employer investigation following receipt of an alleged unlawful act complaint. The department may request or subpoena information from employees, employers and potential witnesses.

A determination will be sent to all interested parties and any aggrieved party can appeal. Information obtained from the investigation may be used as cause for audits of employer files and records (Chapter 50A.40 RCW, WAC 192-570-040 and WAC 192-570-050).

How do I send in a complaint?

Send the completed complaint form and any supporting documentation to the department for investigation. Fax to 833-525-2273, or mail to:

Employment Security Department
Paid Family and Medical Leave Care Center
P.O. Box 19020
Olympia, WA 98507-0020

Questions?

Please contact us if you have questions. We are available Monday-Friday from 8:30 a.m. – 4:30 p.m. at 833-717-2273 or paidleave@esd.wa.gov.

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Unlawful Act Complaint Form

Please complete all sections of the below report. You may add additional pages if necessary. Remember to include your supporting documentation when you submit the form. Investigation timelines may vary due to specific circumstances and will not prevent you from taking the benefit, requesting redetermination and appeals, or contacting private counsel. Please be advised, employers or interested parties may be contacted during the course of the investigation and may be notified with the disposition of the case.

Section one: Your contact information

To be completed by the person filing the complaint (Complainant)

Name *(first and last)*:	
Phone number:	
Email address:	
Mailing address:	
City:	
State:	**Zip:**
Claim ID, Social Security Number, ITIN *(if known)*:	
Is this complaint filed against a business? *(if yes, provide business name and UBI# below if known)*	
Business name:	**UBI#** *(if known)*:
Address:	
City:	**Zip:**
Phone number:	

Section two: Complaint details

Please give as much detail as you can when answering the following questions.

Is this complaint regarding your employment? *(check a box)*	**Yes**	**No**

If no, what is your relationship to the employee?
Name of employee: *(first and last)*
Employee address:
Employee city:
Employee zip:
Phone number:

Please describe how the illegal act interfered with, or denied, the ability to apply for or use the Paid Family and Medical Leave program.

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Please describe the discharge or discrimination that resulted because of the employee's participation in the Paid Family and Medical Leave program.
In connection with this complaint filed with the program, describe how the employer discharged or discriminated against you for filing a complaint, participating in any proceeding or testifying against the employer.
Please provide a brief narrative and any attempts you have made to contact your employer or to resolve the issue. If you have made attempts, please describe the results (include dates, names, titles, phone numbers and emails). Include any other details that may help us during the investigation.
Attach copies of correspondence, emails, policies, union contracts, procedures, or anything else you wish to have considered as support for your complaint. If the necessary documentation has not been provided, we may seek additional information from the employer or other interested parties to make the determination.

Section three: Signature

I certify under penalty of perjury that all the information included on this form is true and accurate and I understand that information involving the investigation and determination is to be made available to all interested parties (RCW 50A.40.020).

Signature:	**Date:**

Mail or fax to: Employment Security Department, Paid Family and Medical Leave Care Center, PO Box 19020 • Olympia, WA 98507-0020 • Fax: 833-525-2273