



Missouri Department of Economic Development  
Missouri Division of Workforce Development

Missouri Division of Workforce Development is an equal opportunity employer/program.  
Auxiliary aids and services are available upon request to individuals with disabilities.  
Missouri TTY Users can call (800) 735-2966 or dial 7-1-1.

## WIA (WORKFORCE INVESTMENT ACT) GENERAL COMPLAINT

### Complainant Information *(please print or type)*

|                     |       |           |                                     |  |   |
|---------------------|-------|-----------|-------------------------------------|--|---|
| FIRST NAME          |       | LAST NAME |                                     |  |   |
| HOME STREET ADDRESS |       |           |                                     |  | TELEPHONE NUMBER <i>(include Area Code)</i> |
| CITY                | STATE | ZIP CODE  | EMAIL ADDRESS <i>(if available)</i> |  |   |

Complainants with disabilities will be accommodated during the complaint process. If an accommodation is required regarding communication or accessibility of location, please indicate in the space below the kind of accommodation required, e.g. accessible location, deaf interpreter (please indicate type of sign language), notification of results and/or hearing dates in alternative format such as Braille, large print, or audio format.

### Respondent Information (the person or entity that the complaint is being filed against) *(please print or type)*

|                          |       |          |                                     |   |
|--------------------------|-------|----------|-------------------------------------|---|
| NAME of PERSON OR AGENCY |       |          |                                     | TELEPHONE NUMBER <i>(include Area Code)</i> |
| STREET ADDRESS OF AGENCY |       |          |                                     |   |
| CITY                     | STATE | ZIP CODE | EMAIL ADDRESS <i>(if available)</i> |   |

### Nature of Complaint *(please print or type)*

Provide a clear and brief statement of the facts in the space below. Include relevant dates that will assist in the investigation and resolution of the complaint. If additional space is needed, use the reverse side of this form or attach additional sheets.

**Attest:** *"The above information is true and correct to the best of my knowledge."*

\_\_\_\_\_  
*Signature of Complainant*

\_\_\_\_\_  
*Date*

### FOR OFFICIAL USE ONLY

|   |  |                  |      |       |          |
|---|--|------------------|------|-------|----------|
| PERSON RECEIVING COMPLAINT                  |  | JOB TITLE/AGENCY |      |       |          |
| STREET ADDRESS OF AGENCY                    |  |                  | CITY | STATE | ZIP CODE |
| TELEPHONE NUMBER <i>(include Area Code)</i> |  | EMAIL ADDRESS    |      |       |          |