COLORADO
Department of
Labor and Employment

Division of Family and Medical Leave Insurance
633 17th Street, Suite 900
Denver, CO 80202 | (303) 318-8000 | cdle.colorado.gov

Family and Medical Leave Insurance Division Retaliation & Interference Complaint Form

This is the Colorado Family and Medical Leave Insurance (FAMLI) Division's Complaint form. This form can be used for paid family and medical leave insurance violations such as retaliation and interference. The FAMLI Division's process is a free service available to employees and other protected individuals, regardless of immigration status, who do not have an ongoing claim in court.

Pursuant to 7 CCR 1108, Section 8.3.5, the filing of a complaint with the FAMLI Division does not guarantee your complaint will be investigated. All investigative decisions are discretionary. Please be aware that in the event the FAMLI Division decides to investigate your complaint, which can take several months to complete, someone from the FAMLI Division will contact you.

For more information about the law and rules enforced by the FAMLI Division, the FAMLI Division's complaint process, or any other questions, call 1-866-263-2654. Our call center hours of operation are Monday-Friday, 8 a.m.- 4 p.m. (Mountain Standard Time). You may also visit our website at famli.colorado.gov or email CDLE_FAMLI_RI@state.co.us. The FAMLI Division's mailing address is 633 17th Street, Suite 900, Denver, CO 80202.

Type(s) of Complaints

The FAMLI Division will only accept and investigate complaints that allege violations of the FAMLI Act. This Complaint form is specific to allegations of Retaliation & Interference. It is unlawful for an employer or any other person to interfere with, restrain, or deny the exercise of, or the attempt to exercise any right under the FAMLI Act. See the complete definitions of Retaliation and Interference in 7 CCR 1107-7, Sections 7.2.6 and 7.

Retaliation & Interference Under the FAMLI Act
You were retaliated against and/or your rights under the FAMLI Act were interfered with because: Examples may include – • You used or tried to use paid family and medical leave; • You defended your rights or another's rights to paid family and medical leave; • You told another individual about or helped an individual use paid family and medical leave; • You made a complaint about or helped with an investigation related to these rights; • Your employer failed to provide notice of your rights under the FAMLI Act; • Your employer failed to reinstate you upon returning from paid family and medical leave; or • You engaged in any other protected activity under the FAMLI Act.

Documents to Include

IMPORTANT! Please include copies of all documents you have that will help the FAMLI Division understand your complaint when you submit it. Do NOT submit originals. These might include:

- Emails and text messages with your Employer about the issue
- Complaints you made to your Employer about the issue
- Employment handbooks or policies
- Any signed agreements
- Contact information for any witnesses
- Any other files that are relevant to your claim(s)

Please feel free to attach additional documents to your answers in the event you run out of space in the form.

Please complete all fields marked with an asterisk (*) that are relevant to your claim(s). You do not need to fill out, or print, Sections that do not relate to your complaint. Don't forget to include your signature on page 10.

Section A: Complainant Information *(Please fill in this information about the person with the claim.)*		
☐ Mr. ☐ Mx. ☐ Ms ☐ Ind.	First Name*	Last Name*
Email		
Phone		Phone 2
Is it okay for the FAMLI Division to send text messages?* ☐ Yes ☐ No		If yes, to what cell phone number?*
Mailing Address (Street/PO Box) *(This is the address where mail is sent to you. Sometimes this is different from the physical address where you live.*)		
City	State	Zip Code
What language do you prefer to use?* ☐ English ☐ Spanish ☐ Other		
If "Other," do you need an interpreter?* ☐ Yes ☐ No If yes, please list the language needed*:		How would you like to receive written communications from the Division? ☐ Mail ☐ Email ☐ Both

Section B: Authorized Representative (*If you do not have an authorized representative, please skip to Section C.*)		
You can choose to have someone called an "Authorized Representative" help you with your claim. This could be an attorney, a relative or friend, an organization, or anyone else who you want to help you file the claim, answer questions from the FAMLI Division during the investigation, or make decisions about the claim. By having and authorizing a representative, you are allowing 1) the FAMLI Division to request or share information and documents about this claim to the representative; 2) the representative to share information and documents with the FAMLI Division, and 3) the representative to make decisions for you about this claim.		
☐ Mr. ☐ Mx. ☐ Ms ☐ Ind.	First Name*	Last Name*
Name of Organization		Authorized Representative Relationship
Phone		Phone 2
Email		Fax Number
Mailing Address (Street/PO Box)		
Mailing City	Mailing State	Mailing Zip Code
By adding this Authorized Representative, I have read and understood the conditions under the Authorized Representative section of this form and authorize the Division to interact with the individual/organization listed as my authorized representative. ☐ * I agree and allow this person to be my Authorized Representative.		

Section C: Employer Information *(To add multiple employers to your claim, please print and complete additional copies of Section C (page 4).)*

Name of Business or Employer*	Business Type: What does the employer do or sell?*:	
Business Mailing Address (often found on pay statements or paychecks)		
Mailing City	Mailing State	Mailing Zip
First Name of Person In Charge	Last Name of Person In Charge	
First Name of Human Resources Contact	Last Name of Human Resources Contact	
Is the company still in business? ☐ Yes ☐ No ☐ I don't know	Total Number of Employees (if known)	Total Number of Contractors (if known)

Worksite Address

Address where you worked (if different from employer's mailing address)		
Worksite City	Worksite State	Worksite Zip Code

Employer Phone and Email Addresses

Company Phone Number	Phone Type ☐ Work ☐ Daytime ☐ Cell ☐ Alternate ☐ Other	
Human Resources Phone Number		
Person in Charge Email	Email Type	
Human Resources Contact Email		

Section D: Employment Information

What is your job title?

Describe what you did for the employer.*

Date you started working for the employer*	Are you still working for the employer?* ☐ Yes ☐ No

If no, reason for separation*	If no, last date worked*
☐ Terminated/Laid Off ☐ Quit/Retired ☐ Other:	

Section E: Court Filings (*If you did not file a case in court related to this Complaint, skip to Section F)*

If "yes," on what date did you file the complaint or case in court?*	In what state did you file a complaint or case in court?*	What was the result of the complaint or case you filed in court?*

Section F: Retaliation Claims *(Please fill out this section ONLY if you have a Retaliation Claim. If you do NOT have a Retaliation Claim, please skip to Section G.)*

If you had multiple positions with the business, list your titles and the dates you held the positions.

How do you believe you were retaliated against?* (check all that apply)

- ☐ Terminated/ laid off
- ☐ Harassed or threatened
- ☐ Disciplined
- ☐ Demotion
- ☐ Denial or promotion
- ☐ Reduction of work hours
- ☐ Reduction in pay
- ☐ Evicted from employer-provided housing
- ☐ I experienced another type of retaliation

Dates of incidents*

Describe in detail what happened. * (attach additional pages as necessary)

Do you think the business or entity knew about your activity that was protected by law?*

- ☐ Yes
- ☐ No
- ☐ I don't know

If yes, explain why you think the business knew:

Name(s) and title(s) of the person or people you believe retaliated against you.*

What were the reasons the business gave for its action(s), if any:*

What do you think was the actual reason(s) for its action(s)?*

How have you been harmed by the business's actions? (e.g., financially, emotionally, fear of additional retaliation)*

Are you interested in a settlement with the business?*

- ☐ Yes
- ☐ No
- ☐ I don't know

Section G: Interference Claims *(Please fill out this section ONLY if you have an Interference Claim. If you do NOT have an Interference Claim, please skip to Section I.)*

You indicated that your employer interfered with, restrained, or denied the exercise of your rights under the FAMLI Act. Please answer the following questions.

Is there a poster in your workplace (in a place where you could/can easily see it) that explains your rights under the FAMLI Act?*

- ☐ Yes
- ☐ No
- ☐ I don't know

Did you receive written notice from your employer advising you of your rights under the FAMLI Act?

- ☐ Yes
- ☐ No
- ☐ I don't know

How do you believe that your employer interfered with your rights under the FAMLI Act?*

- ☐ Discouraged me from taking paid family and medical leave
- ☐ Discouraged me from talking about paid family and medical leave
- ☐ Harassed or threatened me
- ☐ Failed to reinstate me upon returning from paid family and medical leave
- ☐ Requested confidential information about my paid family and medical leave request
- ☐ I experienced another type of interference (explain):

Date(s) of instances (if applicable):*

Describe in detail what happened (attach additional pages if necessary)*

Name(s) and title(s) of the person or people who you believe interfered with your rights under the FAMLI Act:

What reason(s) did the business give for its action(s), if any?*

What do you think were the actual reasons for its action(s):*

Describe what you hope happens because of this complaint (e.g, reinstatement to your former position, for the business to comply with the law):*

Are you interested in a settlement with the business?*

- ☐ Yes
- ☐ No
- ☐ I don't know

Section H: Witnesses (*Attach additional pages if needed. If you do not have any witnesses, skip to Section I*)

First and Last Name:

Job Title (if they are an employee of the business):

Mailing address:

Phone number:

Email address:

What did that person see or hear?

Please provide any additional information we need to understand your claim(s)?

Section I: Affirmations and Signature	
Are you the complainant (person making the complaint), or the complainant's authorized representative?* ☐ Yes ☐ No	
Name of person completing the form, if not the complainant (person making the complaint)*	Relationship of person completing the form, if not the complainant (person making the complaint)*

Please note, the complainant, and the complainant's authorized representative, if one is designated, must sign this page.

Before submitting this complaint:

By signing this Complaint you are agreeing to the following:

- I have been notified and understand that any person providing false information to the FAMLI Division in order to obtain and/or retain anything of value may be subject to criminal prosecution under the laws of the State of Colorado with possible penalties of imprisonment, fines, or both.
- I authorize the FAMLI Division to investigate and assist in this matter.
- I understand that any information supplied to the FAMLI Division may be provided to the employer/principal, the agents of the employer/principal involved in the dispute, and other agencies or individuals as the FAMLI Division deems appropriate and in accordance with federal and state law.
- I understand that the FAMLI Division does not guarantee a resolution to this dispute, and that it may be necessary to pursue the matter further through other methods.
- I understand that if I move, get a new phone number, or have other changes to my contact information, I must let the FAMLI Division know right away. If I do not update my information, and the FAMLI Division cannot contact me, my complaint may be dismissed.
- I understand that the FAMLI Division has discretionary authority to investigate my complaint, and that if the FAMLI Division decides not to investigate, I may have to pursue the matter further in court.
- I declare under penalty of perjury § 18-8-501, et seq., C.R.S. that the information provided is true and correct.

*Complainant's Signature**

Name	Signature	Date

*Authorized Representative's Signature**

Name	Signature	Date

If you have any documents to support your claim, please include them with this Complaint Form when you submit it. Please mail, email, or deliver your completed Complaint Form and attached documentation to:

Colorado Division of Family and Medical Leave Insurance
Attn: Policy Division, 9th Floor
633 17th Street, Denver, CO 80202
Main: (303) 318-8000 | Toll Free: 1-866-263-2654
Email: cdle_famli_ri@state.co.us