CITY OF LOS ANGELES EMPLOYEE COMPLAINT FORM

Please complete, sign and email this form to:

BCA.EEOE@LACITY.ORG

For more information: https://bca.lacity.gov

The information provided on this form is completely confidential.
If available/applicable, please attach a copy of your most recent paycheck to this form.

Mark the corresponding box(es) below for the Ordinance(s)/Program(s) you wish to file your complaint:

☐ Living Wage Ordinance ☐ Equal Benefits Ordinance ☐ Affirmative Action/Equal Employment ☐ Worker Retention Ordinance

First Name: _____ Last Name _____ MI: _____ Social Security #: _____

Your Street Address: _____

City: _____ State: _____ Zip Code: _____ Email Address: _____

Home Phone Number _____ Work Phone Number: _____

Name of Supervisor: _____

Company Name: _____

Company Address: _____

City: _____ State: _____ Zip Code: _____ Company Phone Number: _____

Work Site Address: _____

City: _____ State: _____ Zip Code: _____

City Department Awarding Contract (if known): _____

Your Current Job Title: _____ Are you part of a Union? Yes ☐ No ☐

Hourly Rate Paid: $ _____ Overtime Rate Paid: $ _____

Do you receive health benefits? Yes ☐ No ☐ If yes, how much do you pay for your benefits? $_____

Employee Complaint (Be as detailed as possible. Continue on the next page if needed):

_____

_____

_____

_____

_____

_____

_____

By signing below, I certify that the information provided in this document is true and correct to the best of my knowledge.

_____ _____

Employee's Signature Date

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Date