Northern Arizona University / Facility Services
INJURY AND ILLNESS
PREVENTION PROGRAM

REVISION DATE: 4/4/2015

INTRODUCTION

Arizona is a state plan state, which means that it operates its own state Occupational Safety and Health program under the authorization of the federal Occupational Safety and Health Administration (OSHA).

The Arizona Division of Occupational Safety and Health (ADOSH) is part of the Industrial Commission of Arizona (ICA), and is responsible for occupational safety and health issues within Arizona, excluding mining operations, Indian Reservations, and federal employees.

STATE REGULATIONS

The majority of ADOSH regulations are in agreement with, and have adopted by incorporation, federal OSHA standards 29 CFR 1910 and 1926. Some businesses must adhere to standards that are more stringent as defined by the state. In Arizona, there are state-specific regulations that govern construction and agriculture.

NOTE: The chapters that follow this foreword contain information that is aligned, at a minimum, to OSHA standards. If an applicable OSHA standard does not exist, or is superseded by another regulatory agency or state-specific requirement, the most stringent standard available will be provided.

STATE REQUIREMENTS

The safety and health requirements for the state of Arizona are defined in the Arizona Revised Statutes (ARS). The following sections provide general requirements for all industries, including information regarding worker protection and complaint procedures.

LABOR POSTERS

In addition to the required federal notices, the state of Arizona requires employers to post the following information in a place where employees can easily see it:

- Minimum Wage poster (English and Spanish)
- Notice to Employees (Workers Compensation) poster (bilingual)
- Work Exposure to Bodily Fluids (HIV, AIDS, Hepatitis “C”)
- Work Exposure to MRSA, Spinal Meningitis, or Tuberculosis (TB)
- Employee Safety and Health Protection poster (bilingual)

REPORTING

REPORTING OF INJURIES AND ILLNESSES

Employers must report to ADOSH all workplace accidents that involve a fatality, or involve the hospitalization of three or more employees. This report must be made **within eight (8) hours** following the incident. To report an incident to ADOSH, call (602) 542-5795 or toll-free at (855) 268-5251. If you call outside of regular business hours, please leave a message, and someone will return your call as soon as possible.

OFFICE LOCATIONS

ADOSH has offices at the following locations:

Phoenix Office	**Tucson Office**
800 W. Washington St. Phoenix, AZ 85007 (P.O. Box 19070, Phoenix AZ 85005-9070) Phone: (602) 542-5795 Toll Free: (855) 268-5251 Fax: (602) 542-1614	2675 E. Broadway Blvd. Tucson, AZ 85716 Phone: (520) 628-5478 Toll Free: (855) 268-5251 Fax: (520) 322-8008

REPORTING UNSAFE WORKPLACES

If you are an employee or employee representative, and believe you or another employee are/is exposed to a condition that is immediately dangerous to life or health, you should first attempt to resolve the matter with the employer. If that is not possible, contact ADOSH at (602) 542-5795 or toll-free at (855) 268-5251, for guidance. If you call after business hours, please leave a message and someone will return your call as soon as possible.

DISCRIMINATION

Under Arizona Revised Statute (ARS 23-425), employees have 30 days to file a complaint if they believe they have been discriminated against. ADOSH investigates complaints and pursues appropriate corrective action. Upon receipt of your completed Discrimination Statement, an investigator will call you as soon as possible to start the investigation.

Please save any evidence bearing on your complaint, such as notes, minutes, discharge slips, letters, pay stubs, etc., and have them ready when the investigator calls. It will be helpful if you write down a brief factual account of what happened and prepare a list of potential witnesses. When ADOSH receives your completed questionnaire, it will advise the employer of the charge and request a written position.

Every effort will be made to thoroughly review and evaluate your complaint as expeditiously as possible. It is your responsibility to advise ADOSH of any changes to your address or telephone number, and your continued attention to the complaint is appreciated.

REFUSAL TO PERFORM UNSAFE WORK

Arizona employees who refuse to perform work in conditions where there is an imminent danger to life or health may be protected under state and federal laws. OSHA recommends that employees first address the issue with their employer before taking action.

Refusing to perform work is recognized favorably for the employee only when it is done in good faith, in an imminently dangerous workplace where there is not enough time to contact OSHA, and when the employee remains readily available to perform other assigned tasks. Employees who simply walk off the job will not be protected.

WORKERS' COMPENSATION

It is the responsibility of an injured worker to file a claim within one year of the date of an injury. The injured worker should also notify the employer as soon as possible that a work-related injury has occurred. A claim is made by filling out and signing either a **Worker's and Physician's Report of Injury** at the doctor's office, or a **Worker's Report of Injury**, and filing either report with the ICA. Both of these reports constitute a "claim form."

NOTE: Employers are required to file an **Employer's Report of Injury**; however, this is not a claim. It is only a report of the injury.

Workers wishing to inquire about a compensation claim may contact the Claims Division by calling:
Phoenix: (602) 542-4661
Tucson: (520) 628 5181

Do not send emails (or attachments to emails) that contain sensitive or personal information (such as social security numbers) to the ICA because neither the website nor email is secure. Instead, fax such materials to the fax number below, or mail paper copies to the ADOSH office locations listed above.

The fax number at either office is: (602) 542-3373.

TRAINING

OSHA requires employers to train employees before they perform any task that may endanger their health or safety. Employees must be deemed competent to perform all work tasks, or they will work under the supervision of a competent worker.

Employers must perform a job hazard analysis (JHA) to establish the presence and degree of onsite safety hazards, and to effectively mitigate or handle them. This investigation will include:

- The tasks to be performed
- The equipment to be used and/or operated
- The work environment and atmosphere
- The health and safety risks involved with the work

An onsite, competent professional may conduct training, or the company may choose to hire trainers from an approved third-party source.

RECORDKEEPING

An employer must keep all employee complaints, training records, and other documentation, at the place of employment for a period of at least three years.

ATTACHMENTS

The following pages contain the forms listed below, as well as instructions:

- Unsafe Workplace Complaint form
- Workers' Compensation Claim form
- Employer Injury or Illness Report forms
- Arizona Discrimination Report form
- Release of Employment Records form

The Industrial Commission of Arizona

Division of Occupational Safety and Health

This form is provided to assist an employee representative filing a complaint under A.R.S. § 23-408(F). This form does not constitute the exclusive means to file a complaint with the Division of Occupational Safety and Health ("Division").

Section 23-408.F. of the Arizona Occupational Safety and Health Act provides that an employee or employee representative may request the Division to conduct an inspection when:
1) The employee or employee representative believe that a violation of a safety or health standard exists that threatens physical harm, or
2) The employee or employee representative believe that an imminent danger exists.

An employee or employee representative shall request an inspection under A.R.S. § 23-408(F) by giving written notice to the Director of the Division or the Director's authorized representative. An employee or employee representative shall ensure that the written notice states with reasonable particularity the grounds for the notice and is signed by the employee or employee representative.

The Division shall not disclose the employee's or employee representative's name upon either:
1) A request from an employee or employee representative not to reveal the employee's or employee representative's name because release of the name will result in substantial harm to the employee or employee representative, or
2) A determination by the Division that disclosure of the employee's or employee representative's name may result in substantial harm to any person or to the public health or safety.

Upon receipt of a written notice under A.R.S. § 23-408(F), the Director shall determine whether there are reasonable grounds to believe that a violation or danger exists. If the Director determines that a violation or danger may exist, the Director shall conduct a special investigation under the Occupational Safety and Health Act as soon as practicable. If the Director determines that there are no reasonable grounds to believe that a violation or danger exists, the Director shall provide written notice to the employee or employee representative of that determination. **NOTE:** A person who knowingly makes any false statement, false representation, or false certification in any document filed under the Arizona Occupational Safety and Health Act is guilty of a class 2 misdemeanor. A.R.S. § 23-418(G).

INSTRUCTIONS TO COMPLETE THE NOTICE OF ALLEGED SAFETY OR HEALTH HAZARDS:

Complete all items as accurately and completely as possible. Describe each hazard you think exists in as much detail as you can. If the hazards described in the Notice are not all in the same area, please identify where each hazard can be found at the worksite. If there is any evidence that supports your suspicion that a hazard exists (for example, a recent accident or physical symptoms experienced by employees at the worksite), include the information in your description. If you need more space than is provided on the form, continue on another sheet of paper. (If you type more information into the large text boxes than can be seen all at once, any lines that end up hidden will be saved in the electronic copy of the form but will *not* appear if the form is printed.)

HOW DO I SUBMIT THE FORM?

This depends on whether or not you intend to sign the form. ADOSH will address each complaint received, but how each complaint is handled will depend on several factors, including: the nature of the complaint items, the seriousness of the allegations, the relationship of the complainant to the employer, and whether or not the complaint is signed. While you may fill out the form, save it on your computer, and then submit it as an attachment to an email, doing so will prevent you from signing the complaint form, which may affect the manner in which ADOSH addresses your complaint. If you wish to submit a *signed* complaint, you will need to print the completed form, sign it, then FAX it or submit it via regular postal service to an address below. Alternatively, you can *scan the signed form*, and then submit *that* as an email attachment to comments.adosh@dol.gov.

The Industrial Commission of Arizona **Division of Occupational Safety and Health** **P. O. Box 19070** **Phoenix, AZ 85005-9070** **FAX: (602) 542-1614**	**The Industrial Commission of Arizona** **Division of Occupational Safety and Health** **2675 East Broadway Blvd** **Tucson, AZ 85716-5303** **FAX: (520) 322-8008**

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NOTICE OF ALLEGED SAFETY OR HEALTH HAZARDS
THE INDUSTRIAL COMMISSION OF ARIZONA
DIVISION OF OCCUPATIONAL SAFETY & HEALTH

EMPLOYER'S NAME:			
EMPLOYER'S ADDRESS:			
EMPLOYER'S MAILING ADDRESS:			
MANAGEMENT OFFICIAL:			
EMPLOYER'S TELEPHONE NUMBER:		**FAX:**	
NATURE OF EMPLOYER'S BUSINESS:			
DESCRIBE FULLY THE HAZARDS THAT YOU BELIEVE EXIST, INCLUDING THE NUMBER OF EMPLOYEES EXPOSED:			
SPECIFY EACH LOCATION OR WORK AREA WHERE THE HAZARDS DESCRIBED ABOVE EXIST:			
THIS CONDITION HAS BEEN BROUGHT TO THE ATTENTION OF: (Check all that apply)			
☐ **EMPLOYER**	☐ **FEDERAL OSHA**	☐ **OTHER (Specify):**	
NAME OF PERSON FILING COMPLAINT:		**TELEPHONE:**	
MAILING ADDRESS:			
RELATIONSHIP TO EMPLOYER:	☐ **EMPLOYEE**	☐ **OTHER (Specify):**	
IF THE PERSON FILING THE COMPLAINT IS AN EMPLOYEE REPRESENTATIVE, WHAT ORGANIZATION DOES THE COMPLAINANT REPRESENT (Provide the name and local # of the organization and your title, if appropriate):			
THE IDENTITY OF THE PERSON FILING THIS COMPLAINT WILL BE REVEALED TO THE EMPLOYER UNLESS THE RELEASE OF THE NAME WILL RESULT IN SUBSTANTIAL HARM TO THE PERSON FILING THE COMPLAINT. **PLEASE INDICATE THE FOLLOWING:** ☐ **MY NAME MAY BE REVEALED** **DO NOT REVEAL MY NAME TO THE EMPLOYER BECAUSE**			
SIGNATURE:		**CURRENT DATE:**	

WORKER'S REPORT OF INJURY

MAIL TO: Industrial Commission of Arizona, P.O. Box 19070, Phoenix, AZ. 85005-9070
Do not attach form to email, mail in envelope to address above or FAX to 602-542-3373

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the Industrial Commission of Arizona claims and hearing process are available at the Industrial Commission offices and through the ICA website located at: www.ica.state.az.us

ANSWER ALL QUESTIONS FULLY (Use the back of this form to indicate any further information.)

1. **NAME OF INJURED WORKER:** _____
   LAST **FIRST** **M.I.**
   SOCIAL SECURITY # *: _____ **BIRTH DATE:** _____ **PHONE #: ( )** _____
2. **ADDRESS:** _____
   CITY **STATE** **ZIP CODE**
3. **MARITAL STATUS:** ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** **DEPENDENTS AT TIME OF INJURY:** ☐ **YES** ☐ **NO**
4. **EMPLOYER'S FULL NAME:** _____ **PHONE #:** _____
5. **ADDRESS:** _____
   CITY **STATE** **ZIP CODE**
6. **DATE HIRED:** _____ **WHERE HIRED:** _____ **OCCUPATION:** _____
7. **HOURS WORKED PER DAY:** _____ **PER WEEK:** _____ **HOURLY WAGE:** _____
8. **DID YOU RECEIVE FOOD OR LODGING IN ADDITION TO WAGE?** ☐ **YES** ☐ **NO**
9. **DATE OF INJURY (MO/DAY/YEAR):** _____ **TIME OF INJURY:** _____ ☐ **AM** ☐ **PM**
10. **ADDRESS OR LOCATION OF ACCIDENT:** _____
11. **DID YOU STOP WORK IMMEDIATELY?** _____ **WHEN DID YOU STOP?** _____
12. **WHEN DID YOU REPORT THE INJURY?** _____ **TO WHOM?** _____ **TITLE:** _____
13. **WHEN DID YOU RETURN TO WORK?** _____ **REGULAR WORK** _____ **OTHER WORK** _____
14. **NAMES OF PERSONS WHO SAW THE ACCIDENT:**
    1. **NAME:** _____ **ADDRESS:** _____ **PHONE #:** _____
    2. **NAME:** _____ **ADDRESS:** _____ **PHONE #:** _____
15. **WAS ACCIDENT CAUSED BY ANOTHER PERSON?** _____ **IF SO, BY WHOM?** _____
16. **NAME OF MACHINE OR TOOL THAT MAY HAVE CAUSED THE ACCIDENT:** _____
17. **STATE HOW ACCIDENT HAPPENED:** _____
    _____
18. **BODY PART INJURED:** _____ **DESCRIBE THE INJURY (CUT, BRUISE, ETC.):** _____
19. **WHERE WERE YOU FIRST TREATED? NAME:** _____ **ADDRESS:** _____
20. **WHO TREATED YOU FOR THIS INJURY: NAME:** _____ **ADDRESS:** _____
21. **OTHER THAN THIS INJURY, HAVE YOU LOST TIME FROM WORK DUE TO AN ACCIDENT IN THE PAST 12 MONTHS?** ☐ **YES** ☐ **NO**
    NAME OF STATE WHERE ACCIDENT HAPPENED: _____ **WORK INJURY?** ☐ **YES** ☐ **NO**
22. **OTHER THAN THIS INJURY, HAVE YOU EVER RECEIVED ANY PERMANENT DISABLING INJURY?** ☐ **YES** ☐ **NO**
    DATE OF INJURY: _____ **WORK INJURY:** ☐ **YES** ☐ **NO**
    NAME OF STATE WHERE ACCIDENT HAPPENED: _____
23. **OTHER THAN THIS INJURY, ARE YOU RECEIVING COMPENSATION FOR ANY DISABLING CONDITIONS?** ☐ **YES** ☐ **NO**
    IF SO, FROM WHOM? _____ **AMOUNT?** _____ **WHY?** _____

I make application for all benefits to which I may be entitled under the law. I certify, with full knowledge that it is a crime to make willful, false statements to obtain compensation and that all of my statements on this form are true, accurate, and complete.

_____ _____
Signature of injured worker or authorized representative is REQUIRED. **Date**

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a) (2) (B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THE INDUSTRIAL COMMISSION COMPLIES WITH THE AMERICANS WITH DISABILITIES ACT OF 1990. IF YOU NEED THIS DOCUMENT IN ALTERNATIVE FORMAT, CONTACT CLAIMS AT (602 542-4661).

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment.

ARIZONA REVISED STATUTES 23-908 & 23-1061

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

MAIL TO: (CARRIER NAME & ADDRESS)

FOR CARRIER USE ONLY

FOR OSHA PURPOSES ONLY

OSHA Case #_____

RECORDABLE INJURY

EMPLOYEE

1. LAST NAME | FIRST | M.I. | 2. SOCIAL SECURITY NUMBER * | 3. BIRTH DATE

4. HOME ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 5. TELEPHONE

6. SEX ☐ MALE ☐ FEMALE | 7. MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYER

8. EMPLOYER'S NAME | 9. POLICY NUMBER | 10. NATURE OF BUSINESS (MANUFACTURING, ETC.)

11. OFFICE ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE | 12. TELEPHONE

ACCIDENT

13. DATE OF INJURY OR ILLNESS | 14. TIME OF EVENT ☐ A.M. ☐ P.M. | 15. TIME EMPLOYEE BEGAN WORK ☐ A.M. ☐ P.M. | 16. DATE EMPLOYER NOTIFIED OF INJURY

17. LAST DAY OF WORK AFTER INJURY | 18. DATE OF RETURN TO WORK | 19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED

20. CLASS CODE ON PAYROLL REPORT | 21. EMPLOYEE'S ASSIGNED DEPARTMENT | 22. DEPARTMENT NUMBER | 23. DID INJURY OCCUR ON EMPLOYER PREMISES? ☐ YES ☐ NO

24. ADDRESS OR LOCATION OF ACCIDENT | CITY | COUNTY | STATE | ZIP CODE

25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." *Examples: "strained back", "chemical burn, hand", "carpal tunnel syndrome."*

26. PART OF BODY INJURED | 27. FATAL ☐ YES ☐ NO | 28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH

29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO | NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL | ADDRESS (STREET, CITY, STATE & ZIP CODE)

30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ YES ☐ NO | IF HOSPITALIZED, HOSPITAL NAME | ADDRESS (STREET, CITY, STATE & ZIP CODE)

31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON

CAUSE OF ACCIDENT

32. **WHAT HAPPENED?** Tell us how the injury occurred. *Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."*

33. **WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?** *Examples: "concrete floor", "chlorine", "radial arm saw." If this question does not apply to the incident, leave it blank.*

34. **WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples: "Climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."*

35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ☐ YES ☐ NO | 37. HOURS PER DAY EMPLOYEE WORKED FROM A.M. P.M. THRU A.M. P.M. | 38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ☐ YES ☐ NO | 39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY

IMPORTANT

IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

40. DATE OF LAST HIRE | 41. WAS WORKER PAID FOR DAY OF INJURY? ☐ YES ☐ NO IF YES, $ | 42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ☐ YES

43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR | 44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE $ PER HOUR ☐ DAY ☐ WEEK ☐ MONTH ☐ | 45. IS EMPLOYEE FURNISHED ☐ LODGING ☐ BOARD ☐ BOTH VALUE $

46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)

47. DOES EMPLOYEE CLAIM DEPENDENTS? ☐ YES ☐ NO

IMPORTANT

IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55

48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR | 49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK

50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEEDING INJURY FROM THRU $

51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $

52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY | 53. WAGE BEFORE INCREASE $ | 54. WAGE AFTER INCREASE $ | 55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $

AUTHORIZED SIGNATURE

DATE | AUTHORIZED SIGNATURE | TITLE

NOTE TO EMPLOYER:
1. Mail one copy to the Industrial Commission within 10 days.
2. Mail one copy to your insurance carrier within 10 days.
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries as required by the Federal Occupational Safety and Health Act of 1970.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a) (2) (B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number. Form ICA-04-0101 (Rev. 7/01). THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE.

Print this form at www.ica.state.az.us/claims/forms/claims_employerreportofinjury.pdf

Discrimination Complainant:

Because of the large volume of such inquiries regarding discrimination complaints, we ask that you please complete the following Discrimination Statement and return it to ADOSH at 800 W. Washington St., Phoenix, AZ 85007. **Please keep in mind that by statute, your written discrimination complaint must be received by this office within 30 calendar days of the alleged discriminatory act, or it will not be investigated.** Upon receipt of your completed Discrimination Statement, an investigator will call you as soon as possible to start the investigation.

Please save any evidence bearing on your complaint such as notes, minutes, discharge slips, letters, pay stubs, etc., and have them ready when the investigator calls. It will be helpful if you could write down a brief factual account of what has happened and prepare a list of any potential witnesses involved. When we receive your completed questionnaire, we will advise the employer of the charge and request a written position. Every effort will be made to thoroughly review and evaluate your complaint as expeditiously as possible. It is your responsibility to advise this office of any changes in your address or telephone number, and your continued interest will be appreciated.

Finally, please be advised that as a complainant, you have the right to concurrently file a complaint under section 11(c) with federal OSHA within 30 days of the alleged retaliatory action, if you are filing against a private sector employer. Concurrently filing a complaint with OSHA will protect your rights to seek a remedy through OSHA in the event that ADOSH reaches a decision with which you do not agree. You may contact federal OSHA, Region IX, at 415-625-2547.

Sincerely,

ADOSH

DISCRIMINATION STATEMENT

I, _____, reside at _____
(Name) (Street Address)
In _____, _____, _____.
(City) (County) (State) (Zip)
My telephone number is: Area Code ( ) _____.
(Number)
I have been employed by: _____.
(Name of Employer)
Located at: _____.
(Address of Employer)

Employer's telephone number: Area Code ( ) _____.
(Number)
My job classification is/was: _____

NARRATIVE

NOTE: The narrative must describe in detail the events surrounding the actions which you claim to be in violation of A.R.S. § 23-425. Therefore, you must include in your narrative the following information: (1) Craft or description of work you did, (2) The reason you believe your employer discharged you or discriminated against you, (3) The date and time the discharge or discrimination occurred, (4) The location where the discharge or discrimination occurred, (5) Your supervisor's name, (6) The names, addresses, and phone numbers of witnesses who will substantiate your claim, (7) A detailed description (including dates, times, locations, witnesses and persons involved) of events leading up to your discharge or discrimination, (8) Your objective in filing this discrimination complaint, (9) Are you employed at the present time? If so, by whom? (10) A phone number where you can be contacted between 7 a.m. and 6 p.m., Monday through Friday. You may use additional paper if needed.

I have read and had an opportunity to correct this statement consisting of ____ pages and swear that the information contained herein is true and correct to the best of my knowledge and belief. **Note**: I am aware that it is unlawful for me to make any false statement, representation or certification in this document which is being fill pursuant to the Arizona Occupational Safety and Health Act of 1972 [A.R.S § 23-418 (H)]. Violation of this requirement is a Class 2 misdemeanor and carries a penalty up to $750.00.

Signature of Complainant: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

To Whom It May Concern:

The undersigned, _____, does hereby authorize
Print Name

the Industrial Commission of Arizona to obtain copies of any and all personnel and employment records involving his/her employment with _____

Dated this _____ day of _____, 20_____.

_____
Signature