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## Office of Congressional Workplace Rights Claim Form

### Instructions

This form may be used by legislative branch employees to file a claim with the Office of Congressional Workplace Rights (OCWR). Claims must allege violation(s) of the Congressional Accountability Act of 1995 (CAA), as amended by the Congressional Accountability Act of 1995 Reform Act of 2018 (Reform Act). *See* 2 U.S.C. § 1302(c); 2 U.S.C. §§ 1311-1317.

The OCWR's role is to be a neutral fact-finder and to resolve claims as promptly as possible. The OCWR does not act as an advocate for either party during the process. The OCWR essentially has two options for resolving claims, either through mediation or adjudication.

**You have the right to receive assistance from an OCWR Confidential Advisor.**

**IMPORTANT: If you have questions or concerns about how to complete this Claim Form, the Administrative Dispute Resolution (ADR) process of the OCWR, or the specific employment laws applicable to your workplace, and you do not have a designated attorney representative, you have the right to consult, at no cost to you, with an OCWR Confidential Advisor. The Confidential Advisor can inform you about your rights under the CAA and the OCWR's procedures, discuss your concerns, and consult with you regarding your claims and the options that are available to you under the CAA for resolving them. The Confidential Advisor will provide these services to you on a privileged and confidential basis.**

**The Confidential Advisor may not, however, act as your representative in any proceeding under the CAA. If you would like to request the assistance of the Confidential Advisor, please contact the OCWR at (202) 724-9250 or send an email to [ConfidentialAdvisor@ocwr.gov](mailto:ConfidentialAdvisor@ocwr.gov).**

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Office of Congressional Workplace Rights  
110 Second Street, SE, Room LA-200 | Washington, DC 20540-1999  
(202) 724-9250 (O) | (202) 426-1913 (F)  
[www.ocwr.gov](http://www.ocwr.gov)

**Filing and Submission:**

Your claim must be filed no later than 180 days after the alleged violation(s) of the CAA. You must either be an employee, a former employee, an applicant, an intern, a detailee, or a fellow of the legislative branch at the time of the violation(s).

After you have submitted your Claim Form, an electronic copy will be available to you in your secure claim folder created by the OCWR on an online platform. The OCWR will provide you a link to your secure claim folder via email. Please be advised, **the OCWR also will provide a copy of your Claim Form to the employing office.** Your claim will be processed in accordance with the CAA and the OCWR Procedural Rules. You have the option to either pursue voluntary mediation or adjudication of your claim for resolution of your dispute.

The Claim Form must either be e-filed (<https://socrates.ocwr.gov>), emailed ([OCWRrefile@ocwr.gov](mailto:OCWRrefile@ocwr.gov)), faxed (202-426-1913), mailed, or hand-delivered to: Office of Congressional Workplace Rights, John Adams Building, 110 Second Street, SE, Room LA-200, Washington, D.C. 20540-1999.

**Confidentiality:**

The OCWR shall maintain confidentiality in the confidential advising process, mediation, and in all proceedings and deliberations of the OCWR Hearing Officers and the OCWR Board of Directors, including any related records, in accordance with 2 U.S.C. § 1382(d)(2)(B) and § 1416(a)-(b), except as provided in 2 U.S.C. § 1382(d) and § 1416(c)-(e). However, during the course of any proceeding under the CAA, a covered employee is not prohibited from disclosing the factual allegations underlying the claim, and an employing office is not prohibited from disclosing the factual allegations underlying the employing office's defense to the claim. *See* 2 U.S.C. § 1416(f).

At any time, an employee or an employing office may seek information on the OCWR's procedures and on the protections, procedures, and rights and responsibilities available under the CAA. The OCWR will maintain the confidentiality of requests for such information.

For more information about filing a claim, please refer to the OCWR website at [www.ocwr.gov](http://www.ocwr.gov).

***If you have any additional questions, please contact the OCWR at (202) 724-9250.***

**Claim Requirements:**

It is important you complete this Claim Form thoroughly, providing all required information and describing the facts and circumstances that you believe violated your rights under the CAA. A claim filed with the OCWR must contain the following:

- **Section A:**
  - Your contact information, including full name, job title, mailing address, preferred phone number, secondary phone number, and at least one personal email address, if available; and
  - Information about the employing office involved, including the employing office's address and phone number.
- **Section B:**
  - The basis(es) of your claim and the specific section(s) of the CAA that applies.
- **Section C:**
  - A description of the action or conduct that happened and why you believe it violates the section(s) of the CAA you specified.
- **Section D:**
  - Specific details about the alleged violation.
- **Section E:**
  - A brief statement of what you expect out of your claim;
- **Declaration:**
  - The **signed declaration** included at the end of this form.

*(continued on the next page)*

**Section A:**

**Contact information**

**Name:** \_\_\_\_\_

**Job title:** \_\_\_\_\_

**Mailing address:** \_\_\_\_\_

\_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Preferred phone number** (personal phone, if available): \_\_\_\_\_

**Secondary phone number** (work/home/cell phone): \_\_\_\_\_

**Preferred email** (personal email, if available): \_\_\_\_\_

**Secondary email:** \_\_\_\_\_

**Employing office**

**Employing office involved:** \_\_\_\_\_

**Employing office's address:** \_\_\_\_\_

\_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Employing office's phone number:** \_\_\_\_\_

*(continued on the next page)*

**Section B:** Please select the basis(es) of your claim. From the following provisions of the CAA, check all that apply. (For any alleged violation(s) under 2 U.S.C. § 1311, please fill out the relevant information – for example, “Sex: Female”; “Age: 53”; etc.)

**Select one or more:**

<b>(box) Discrimination</b>	<b>(box) Harassment</b>	<b>(box) Both (2 U.S.C. § 1311)</b>
(box) Race: _____	(box) Color: _____	
(box) Religion: _____	(box) National Origin: _____	
(box) Sex: _____	(box) Gender: _____	
(box) Sexual harassment		
your sex: _____		
sex of the person you believe harassed you: _____		
(box) Disability: _____	(box) Age: _____	

**(box) Family and Medical Leave (2 U.S.C. § 1312)**

(box) Leave denial or Interference	(box) Retaliation
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**(box) Fair Labor Standards (2 U.S.C. § 1313)**

(box) Minimum wage	(box) Overtime pay
(box) Equal pay	(box) Child labor
(box) Lactation	(box) Other

**(box) Employee Polygraph Testing Protection (2 U.S.C. § 1314)**

**(box) Notification of Office Closings or Mass Layoffs (2 U.S.C. § 1315)**

**(box) Uniformed Services Employment & Reemployment Rights (2 U.S.C. § 1316)**

(box) Army	(box) Marines	(box) Navy	(box) Air Force
(box) Reserves	(box) National Guard	(box) Other	

**(box) Veterans’ Employment Opportunities (2 U.S.C. § 1316(a))**

(box) Army	(box) Marines	(box) Navy	(box) Air Force
(box) Reserves	(box) National Guard	(box) Other	

**(box) Reprisal (2 U.S.C. § 1317)**

(box) I opposed a practice made unlawful by the CAA.

(box) I initiated proceedings, filed a claim, or testified, assisted, or participated in a hearing or other proceeding under the CAA.

**(box) Genetic Information Nondiscrimination and Privacy (2 U.S.C. § 1302(c))**



**Section D:** Please provide specific details about the alleged violation.

**Date(s) of the alleged violation:** \_\_\_\_\_

**Place(s) of the alleged violation:** \_\_\_\_\_

**Name(s) & Title(s) of the individuals involved in the alleged violation:** \_\_\_\_\_

Are you claiming that a Member of Congress (1) personally harassed you because of your race, color, religion, national origin, sex, gender, disability, age, or service in the military or other uniformed service; or (2) personally retaliated against you because you have raised such a claim of harassment? See 2 U.S.C. §§ 1311, 1316.

Yes

No

Select one or more:  Discrimination       Harassment       Retaliation

**Name of Member:** \_\_\_\_\_

**Section E:** What remedy(ies)/outcome(s) are you seeking to resolve this claim? (For example – reinstatement, promotion, back pay, reimbursement for overtime, reasonable accommodation, etc.)

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## Declaration

You must provide an affirmation as to the truth of the assertions contained in any pleading that you file with the Office of Congressional Workplace Rights (OCWR), pursuant to 2 U.S.C. § 1401(f). All submitted documents must be signed by you personally or, if applicable, by your designated representative.\* Whoever signs the document must provide a mailing address, an email address, and a telephone number.

By submitting this Claim Form to the OCWR, you and/or your representative are certifying that to the best of your knowledge, information, and belief:

(1) it is not being presented for any improper purpose, such as to harass, cause unnecessary delay, or needlessly increase the cost of resolving the matter;

(2) the claims, defenses, and other legal contentions you are advocating are warranted by existing law or by a non-frivolous argument for extending, modifying, or reversing existing law or for establishing new law;

(3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further review or discovery; and

(4) the denials of factual contentions are warranted on the evidence or, if specifically so identified, are reasonably based on belief or a lack of information.

If, after notice and a reasonable opportunity to respond, the OCWR determines that these requirements have been violated, the OCWR may impose an appropriate sanction for such violation.

By signing this Declaration, you and/or your representative affirm that you have read, understand, and will comply with the above-stated requirements.

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**Claimant's signature**

**Date**

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**Representative's signature**

**Date**

*\*If you have a representative, you must designate that representative on a separate Notice of Designation of Representative Form provided by the OCWR.*

Note: Once you submit this Claim Form, you will no longer be able to make changes to this form. You will be able to access an electronic copy of your Claim Form via a link provided to you by the OCWR. You have the right to amend your claim within 15 calendar days of filing the initial claim. For more information on how to amend your claim, please contact the OCWR at (202) 724-9250 or visit our website at [www.ocwr.gov](http://www.ocwr.gov).