



The one. The only.

# Discrimination Complaint Form

First Name	Last Name
Job Title	Office/Facility
Address/City/State/Zip	Phone
Date(s) of Discriminatory Action(s)	Name/Title of Person You Believe Discriminated Against You

Type of Discrimination

<input type="checkbox"/> Age	<input type="checkbox"/> Military Service	<input type="checkbox"/> Religion	<input type="checkbox"/> Other: <div style="border: 1px solid black; width: 150px; height: 40px;"></div>
<input type="checkbox"/> Sexual Orientation	<input type="checkbox"/> Nationality	<input type="checkbox"/> Sex/Gender	
<input type="checkbox"/> Disability	<input type="checkbox"/> National Origin	<input type="checkbox"/> Sexual Harassment	
<input type="checkbox"/> Gender Identity	<input type="checkbox"/> Race	<input type="checkbox"/> Retaliation	

Please explain why you feel you were discriminated against

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Were the actions or behaviors in your complaint directed at, or said to you \_\_\_\_\_ and/or another party \_\_\_\_\_?

Was the incident report to anyone?  Yes  No If yes, who and when? \_\_\_\_\_

What remedy or solution are you seeking? \_\_\_\_\_

If appropriate, are you willing to attempt to resolve your complaint through mediation or another alternative dispute resolution process?  Yes  No

Have you filed a complaint about this/these incident(s) with anyone else?  Yes  No If yes, please provide information regarding who, which organization and the date.

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Signature \_\_\_\_\_ Date \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

Complaint Reviewed By: \_\_\_\_\_ Date Received \_\_\_\_\_