ACCU STAFFING
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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

- ☐ Age
- ☐ Sexual Orientation
- ☐ Disability
- ☐ Gender Identity
- ☐ Military Service
- ☐ Nationality
- ☐ National Origin
- ☐ Race
- ☐ Religion
- ☐ Sex/Gender
- ☐ Sexual Harassment
- ☐ Retaliation
- ☐ Other:

Please explain why you feel you were discriminated against

_____

_____

_____

_____

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.**

_____

_____

Signature _____ **Date** _____

DO NOT WRITE BELOW THIS LINE

Complaint Reviewed By: _____ **Date Received** _____