

DISCRIMINATION COMPLAINT FORM

Date of complaint: _____

Name of Complainant: _____

Are you filling out this form for yourself or someone else (please identify the individual if you are submitting on behalf of someone else):

Who or what entity do you believe discriminated against, you (or someone else)?

Date and place of alleged incident(s):

Names of any witnesses (if any): _____

Nature of discrimination alleged (check all that apply):

<input type="checkbox"/>	Age	<input type="checkbox"/>	Race	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Disability	<input type="checkbox"/>	Sex	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Religion	<input type="checkbox"/>	Sexual Orientation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Color	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	National Origin	<input type="checkbox"/>	Actual or potential parental, family or marital status	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Creed	<input type="checkbox"/>	Pregnancy or related conditions	<input type="checkbox"/>	<input type="checkbox"/>

In the space below, please describe what happened and why you believe that you or someone else has been discriminated against. Please be as specific as possible and attach additional pages if necessary.

I agree that all of the information on this form is accurate and true to the best of my knowledge.

Signature: _____ Date: _____