

WITNESS DISCLOSURE FORM

Name of Witness: \_\_\_\_\_

Date of interview: \_\_\_\_\_

Date of initial complaint: \_\_\_\_\_

Name of Complainant (include whether the Complainant is a student or employee): \_\_\_\_\_

Date and place of alleged incident(s): \_\_\_\_\_

Nature of discrimination alleged (check all that apply):

<input type="checkbox"/>	Age	<input type="checkbox"/>	Race/Color	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Disability	<input type="checkbox"/>	Sex	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Religion/Creed	<input type="checkbox"/>	Sexual Orientation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Marital Status	<input type="checkbox"/>	Socio-economic Background <b>Color</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	National Origin/Ethnic Background/Ancstry	<input type="checkbox"/>	<b><u>Actual or potential parental, family or marital status</u></b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b><u>Creed</u></b>	<input type="checkbox"/>	<b><u>Pregnancy or related conditions</u></b>	<input type="checkbox"/>	<input type="checkbox"/>

Description of incident witnessed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional information: \_\_\_\_\_

\_\_\_\_\_

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

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