



**TITLE VI/504/ADA and Related  
Federal and State Statutes  
Discrimination Complaint Form**

<b>FOR OFFICE USE ONLY</b>	
Date: _____	Reviewer Initials: _____

Name of Complainant: _____	Home Telephone Number: _____	Work Telephone Number: _____
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Mailing Address:  
\_\_\_\_\_

What is the most convenient time for us to contact you about this complaint?  
\_\_\_\_\_

Basis of Discriminatory Action(s):

<input type="checkbox"/> RACE	<input type="checkbox"/> SEX	<input type="checkbox"/> MARITAL STATUS
<input type="checkbox"/> COLOR	<input type="checkbox"/> NATIONAL ORIGIN/ANCESTRY	<input type="checkbox"/> VETERAN'S STATUS
<input type="checkbox"/> RELIGION/CREED	<input type="checkbox"/> PHYSICAL/MENTAL DISABILITY	<input type="checkbox"/> GENETIC INFORMATION
<input type="checkbox"/> AGE	<input type="checkbox"/> MEDICAL CONDITION	<input type="checkbox"/> RETALIATION

Date and place of alleged discriminatory actions. Please include earliest date of discrimination and most recent date of discrimination:  
\_\_\_\_\_  
\_\_\_\_\_

How were you discriminated against? Describe the nature of the action, decision, or conditions of the alleged discrimination. Explain as clearly as possible what happened and why you believe your protected status was a factor in the discrimination. Include how other persons were treated differently from you. (Attach additional page(s), if necessary).  
\_\_\_\_\_  
\_\_\_\_\_

Names of persons (witnesses, fellow employees, supervisors, or others) whom we may contact for additional information to support or clarify your complaint: (Attached additional page(s), if necessary).

<u>Name</u>	<u>Address</u>	<u>Telephone</u>
_____	_____	_____
_____	_____	_____

\_\_\_\_\_  
Signature of Complainant

\_\_\_\_\_  
Date