COMPLAINT FORM

Name:_____

Address:_____

City, State, Zip:_____

Telephone #:_____Date:_____
(Please indicate if this is a TDD or TTY #)

Name of Department you are alleging that discriminated against you: _____

Names of individuals involved:_____

Check one of the following boxes that indicate what the discrimination was based on :

❑disability ❑race ❑age ❑national origin ❑color ❑sex ❑religion ❑age ❑genetics ❑other

1. Please describe in detail why you feel like you have been discriminated. Please give specific law or regulation you think is applicable. Please give specific names, actions, and dates if possible. _____

_____

_____

_____

_____

2. What is the most recent discriminatory action that was taken against you? (Please give specific details.) _____

_____

_____

_____

_____

3. Who took this action against you?_____

4. What is his or her position and your relationship?_____

_____

5. What reasons did they give for making this action?_____

6. State how you have been treated differently from other individuals using the same service or benefiting from the same program. Briefly describe this situation._____

Please note: A copy of this complaint will be forwarded to the department head or supervisor of the department involved in your grievance. If you need additional space you may use the back of these pages or insert additional pages.