

# Discrimination and/or Harassment Complaint Form

Complete this form and return it to the Human Resources department.

PLEASE PRINT OR TYPE – ATTACH EXTRA PAGES IF NECESSARY

1. Provide the following information:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Social Security No./Employee No.: \_\_\_\_\_

Date of Hire: \_\_\_\_\_

Job Title: Department: \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

2. Identify the Respondent(s) and/or Department that allegedly discriminated against you.

Name of Respondent: \_\_\_\_\_

Department: \_\_\_\_\_

Phone Number: \_\_\_\_\_

3. Indicate the basis for the alleged prohibited discrimination and/or harassment:

- |  |   |
|--|---|
| <input type="checkbox"/> Age             | <input type="checkbox"/> Religion           |
| <input type="checkbox"/> Disability      | <input type="checkbox"/> Retaliation        |
| <input type="checkbox"/> National Origin | <input type="checkbox"/> Sexual Harassment  |
| <input type="checkbox"/> Other           | <input type="checkbox"/> Sexual Orientation |
| <input type="checkbox"/> Pregnancy       | <input type="checkbox"/> Whistle Blower     |
| <input type="checkbox"/> Race/Color      |   |

4. Briefly explain the discrimination and/or harassment you believe happened:

a. On what date(s) did the alleged discriminatory act(s) occur?

b. Explain the incident that occurred:

