



PLEASE TYPE OR PRINT

DISCRIMINATION COMPLAINT FORM

NAME (Last, First, MI): _____

HOME PHONE NUMBER: _____

ADDRESS: _____

WORK PHONE NUMBER: _____

<input type="checkbox"/>	Discrimination	<input type="checkbox"/>	Harassment	<input type="checkbox"/>	Sexual Harassment	<input type="checkbox"/>	Retaliation** (See definition below)
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The alleged conduct was based on what factor? (Check all that apply)

<input type="checkbox"/>	Age (40 or over)	<input type="checkbox"/>	Race	<input type="checkbox"/>	Medical Condition	<input type="checkbox"/>	Sexual Orientation
<input type="checkbox"/>	National Origin	<input type="checkbox"/>	Marital Status	<input type="checkbox"/>	Color	<input type="checkbox"/>	Military/Veteran Status
<input type="checkbox"/>	Ancestry	<input type="checkbox"/>	Religion/Creed	<input type="checkbox"/>	Gender Expression	<input type="checkbox"/>	Sex (gender)
<input type="checkbox"/>	Gender Identity	<input type="checkbox"/>	Disability	<input type="checkbox"/>	Genetic Information	<input type="checkbox"/>	Sex (pregnancy)
<input type="checkbox"/>	Other: _____						

**Retaliation can occur after a person files a complaint of discrimination or participates in a discrimination investigation.

Which employment issue is involved? (Check all that apply)

<input type="checkbox"/>	Hiring	<input type="checkbox"/>	Promotion	<input type="checkbox"/>	Transfer
<input type="checkbox"/>	Termination	<input type="checkbox"/>	Differential Treatment	<input type="checkbox"/>	Hostile Work Environment
<input type="checkbox"/>	Other: _____				

Complaint is against which County Office, Agency, or Employee?

Name:	_____
Address:	_____
Phone Number:	_____

Describe circumstances of complaint: Include names, dates, communications, attach supporting documents, etc. Attach additional sheets, if necessary.

Is additional information attached? If yes, how many pages? _____ Yes No

Have you reported this complaint to your Supervisor or Department Head? Yes No

Provide Name, Address and Phone Number of witness(es) who may be contacted. Attach additional list, if necessary.

Name	Address	Phone Number

Describe the corrective action or remedy you are seeking. _____

Have you filed this complaint with any Federal, State or local agency? Yes No


If yes, with whom? EEOC CRD Other: _____

Have you retained a private attorney? If yes, provide information below. Yes No

Name	Address	Phone Number

I declare under penalty of perjury that the facts and circumstances provided above are true and correct to the best of my knowledge and belief. I further authorize the Equal Employment Opportunity Officer or his/her designated representative access to all appropriate personnel, medical, judicial, legal, and/or administrative records or files relevant to the investigation of this complaint. _____ (Initial Here)

Name(First, MI, Last):	Signature:	Date:
Name of EEO Representative:	Signature:	Date:

Human Resources Use Only Date Received	PLEASE SUBMIT COMPLETED FORM TO THE EEO OFFICER OR HUMAN RESOURCES & RISK MANAGEMENT DIRECTOR 940 WEST MAIN STREET SUITE 101 EL CENTRO, CA 92243 (442) 265-1017 or (442) 265-1148
	 Human Resources & Risk Management COUNTY OF IMPERIAL