

DISCRIMINATION COMPLAINT FORM

Date of complaint: _____

Name of Complainant: _____

Are you filling out this form for yourself or someone else (please identify the individual if you are submitting on behalf of someone else): _____

Who or what entity do you believe discriminated against, harassed, or bullied you (or someone else)? _____

Date and place of alleged incident(s): _____

Names of any witnesses (if any): _____

Nature of discrimination, harassment, or bullying alleged (check all that apply):

<input type="checkbox"/>	Age	<input type="checkbox"/>	Physical Attribute	<input type="checkbox"/>	Sex
<input type="checkbox"/>	Disability	<input type="checkbox"/>	Physical/Mental Ability	<input type="checkbox"/>	Sexual Orientation
<input type="checkbox"/>	Familial Status	<input type="checkbox"/>	Political Belief	<input type="checkbox"/>	Socio-economic Background
<input type="checkbox"/>	Gender Identity	<input type="checkbox"/>	Political Party Preference	<input type="checkbox"/>	Other – Please Specify:
<input type="checkbox"/>	Marital Status	<input type="checkbox"/>	Race/Color	<input type="checkbox"/>	
<input type="checkbox"/>	National Origin/Ethnic Background/Ancestry	<input type="checkbox"/>	Religion/Creed	<input type="checkbox"/>	

In the space below, please describe what happened and why you believe that you or someone else has been discriminated against, harassed, or bullied. Please be as specific as possible and attach additional pages if necessary.

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

Signature: _____

Date: _____