# Discrimination Complaint Form

| Name | Phone | Name of Person (s) or Agency that discriminated against you |
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| Your Address—Street (PO Box), City, State, Zip | Name, Address and Position of Person (if known) |
|---|---|
| | |

| Discrimination Because of: | | Date of Alleged Incident |
|---|---|---|
| ☐ Race/Color | ☐ Retaliation | |
| ☐ Sex | ☐ Age | |
| ☐ Disability | ☐ National Origin | |

Explain as briefly and clearly as possible what happened and how you were discriminated against. Indicate who was involved. Describe the corrective action you are seeking. Also attach any written material pertaining to your case.

| Signature | Date |
|---|---|
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