



**DISCRIMINATION/HARASSMENT COMPLAINT FORM**

Name of Complainant	Date form completed
Department	
Home Phone	Work Phone

1. Charge of discrimination/harassment based on: (Check all that apply)
- |   |  |
|---|--|
| <input type="checkbox"/> Race/Color               | <input type="checkbox"/> Sex                             |
| <input type="checkbox"/> Sexual Orientation       | <input type="checkbox"/> Religious Creed                 |
| <input type="checkbox"/> National Origin/Ancestry | <input type="checkbox"/> Disability or Medical Condition |
| <input type="checkbox"/> Age                      | <input type="checkbox"/> Other _____                     |

2. Statement of discrimination/harassment, please provide the following information (use an attached sheet if necessary):

1. Date(s), time(s), and location(s) of the incident/incidences that took place

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2. Description of each incident: e.g., was any physical contact made?, what was said and/or done?, etc.

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3. Name(s) of anyone present during each incident

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4. Anyone with whom you've discussed the incident/incidences

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**Comments**

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Complainant Signature	Date
Complaint Recipient Signature	Date

**ALL COMPLAINTS WILL BE KEPT STRICTLY CONFIDENTIAL!**