DEPARTMENT OF MENTAL HEALTH & ADDICTION SERVICES

Equal Employment Opportunity Office Complaint Form

FORM AA-100

This is a fillable form. Please type in your answers and email to EEOO:

Last Name:	**First Name:**
Facility:	**Location/ Division:**

Race:	**Sex:**	**Shift:**	**Days/Week:**

Position Title:

Immediate Supervisor Name, Title and Phone:

Telephone number(s) where you can be reached: **Work#:**

Home #: **Cell#:** **E-mail:**

Mailing Preference (check which you prefer): ☐ **Work Address** ☐ **Home Address**

Work Address: (Street, City, State, Zip)

Home Address:
If you prefer mail to your home address, please submit on a separate sheet. This information will be kept confidential.

Please check any applicable items below:

I believe that on (mm/dd/yyyy) I have been: ☐ **Discriminated Against** ☐ **Harassed**
(Incident Date)

On the basis of: ☐RACE ☐COLOR ☐RELIGIOUS CREED ☐ANCESTRY ☐AGE (DOB:) ☐SEX
☐SEXUAL HARASSMENT ☐GENDER IDENTITY OR EXPRESSION ☐MARITAL STATUS ☐NATIONAL ORIGIN
☐WORKPLACE HAZARDS TO REPRODUCTIVE SYSTEMS ☐PRESENT / PAST HISTORY OF MENTAL DISABILITY ☐RETALIATION
☐INTELLECTUAL DISABILITY ☐LEARNING DISABILITY ☐PHYSICAL DISABILITY INCLUDING, BUT NOT LIMITED TO BLINDNESS
☐PREGNANCY/ FAMILIAL STATUS ☐GENETIC INFORMATION ☐VETERAN STATUS ☐SEXUAL ORIENTATION
☐PRIOR CONVICTION OF A CRIME (subject to Sec. 46a-79, 46a-80 of C.G.S.) ☐HAIR TEXTURE AND STYLE (CROWN ACT)
☐STATUS AS A VICITIM OF DOMESTIC VIOLENCE

COMPLETE THE FOLLOWING, ONLY IF APPLICABLE:

I believe that on (mm/dd/yyyy) I was retaliated against by (name) for previously opposing a discriminatory practice (Filing or testifying in an Equal Employment Opportunity Office Investigation, CHRO or EEOC grievance).

How was your employment affected? (check any that apply)

☐FAILURE TO HIRE ☐FAILURE TO PROMOTE ☐DEMOTION ☐TERMINATION ☐SUSPENSION OR OTHER CORRECTIVE ACTION
☐POOR SERVICE RATING ☐DENIAL OF TRAINING OR ACCOMMODATION ☐UNEQUAL TREATMENT (PLEASE DESCRIBE):

Please complete page 2 and attach to this form, along with any other documentation.

☐ **I elect to resolve this through mediation if possible**
(Only in cases with no MHAS-20 Work Rule Violation or Equal Employment Opportunity investigations)

By signing below, I understand that I have the right to file my complaint with the Commission on Human Rights & Opportunities (CHRO), and/or the U.S. Equal Employment Opportunity Commission (EEOC), or with any other state, federal or local agency that enforces laws against discriminatory or illegal employment practices. I certify that the information provided herein is true to the best of my knowledge and belief:

E-Signature of Complainant **Date**

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Alleged Violator(s) / Respondent(s): (use separate paper if more space is needed)

NAME	TITLE	UNIT	PHONE #	SHIFT

Witnesses (if any): (use separate paper if more space is needed)

NAME	TITLE	UNIT	PHONE #	SHIFT

Please provide a detailed description of your complaint. Include dates, locations, and times of incidents. *(You may attach additional pages or any other relevant documentation, such as a completed MHAS-20 incident report if applicable).* **Please number allegations if possible.**

☐ **Remedy Requested / How can this be resolved?**

______________________________ ______________________________

E-Signature of Complainant **Date**