# **INTERNAL DISCRIMINATION COMPLAINT FORM**

**DDS EQUAL EMPLOYMENT OPPORTUNITY OFFICE**

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| **Date Submitted:** | **Date of Incident:** |
| **First Name:** | **Last Name:** |
| **Position Title:** |  |
| **Immediate Supervisor Name:** | **Immediate Supervisor Job Title:** |
| **Work Site Address:** |  |
| **Preferred contact number (Home/Cell/Work):** |  |

**Please check any applicable Protected Classes below:**

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|  | **Age** |  | **Physical Disability including, but not limited to, blindness** |
|  | **Ancestry** |  | **Pregnancy/Familial Status** |
|  | **Color** |  | **Race including, but not limited to, ethnic traits historically associated with race** |
|  | **Gender Identity or Expression** |  | **Religious Creed** |
|  | **Genetic Information** |  | **Sex (gender)** |
|  | **Intellectual Disability** |  | **Sexual Harassment** |
|  | **Learning Disability** |  | **Sexual Orientation** |
|  | **Marital Status** |  | **Status as a Veteran** |
|  | **Mental Disability (Present/Past History)** |  | **Status as a Victim of Domestic Violence** |
|  | **National Origin** |  |  |
|  | **Other (please specify):** |

\***Complete the following, ONLY IF APPLICABLE**:

I believe I was retaliated against by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name) for previously opposing a discriminatory practice (e.g., filing or participating in a discrimination complaint process.)

# **INTERNAL DISCRIMINATION COMPLAINT FORM - PAGE 2**

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**Please provide a detailed description of the events you believe were discriminatory.** Include dates, locations, and times of incidents. Please include any potential witnesses or other relevant documentation. Attach additional pages as necessary.

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 **Remedy Requested:** How do you think this situation could be resolved?

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**Signature of Complainant**  **Date**