

EEO INFORMAL COMPLAINT INTAKE FORM

This form will provide preliminary information in order to assist in the initial review of your complaint.

Name:	
Home Address:	City:
State:	Zip:
Home Phone:	
Agency/Division:	Work Phone:
Work Location/Facility:	
Please select your current status: <input type="checkbox"/> Career State Employee <input type="checkbox"/> Former Career State Employee <input type="checkbox"/> Probationary State Employee <input type="checkbox"/> Former Probationary State Employee <input type="checkbox"/> Applicant for State Employment	
Shift or Normal Work Schedule:	Email Address:
Position Title:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Two or More Races	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Immediate Supervisor Name:	Telephone Number:
I believe that I was discriminated against by the following: (Check those that apply) <input type="checkbox"/> Agency <input type="checkbox"/> Supervisor <input type="checkbox"/> Other (Please Specify) _____	
Full Name/Agency you believe discriminated against you:	Position/Title (if applicable)
Address:	Telephone Number:
Most recent date of alleged unlawful action:	
Type of unlawful action (must select one): <input type="checkbox"/> Discrimination <input type="checkbox"/> Harassment <input type="checkbox"/> Retaliation	
If alleging discrimination or retaliation, check alleged unlawful action: <input type="checkbox"/> Hiring <input type="checkbox"/> Training <input type="checkbox"/> Work Assignments <input type="checkbox"/> Demotion <input type="checkbox"/> Suspension without Pay <input type="checkbox"/> Promotion <input type="checkbox"/> Dismissal <input type="checkbox"/> Compensation <input type="checkbox"/> Reduction in Force <input type="checkbox"/> Reasonable Accommodation <input type="checkbox"/> Overall Performance Rating <input type="checkbox"/> Other Terms or Conditions of Employment (Please Specify) _____	
Discrimination Basis: Do you think this happened to you because of (check as appropriate): <input type="checkbox"/> Race <input type="checkbox"/> Sex <input type="checkbox"/> National Origin <input type="checkbox"/> Disability <input type="checkbox"/> Political Affiliation <input type="checkbox"/> Pregnancy <input type="checkbox"/> Color <input type="checkbox"/> Religion <input type="checkbox"/> Genetic Information <input type="checkbox"/> Age(40+) <input type="checkbox"/> Ethnicity <input type="checkbox"/> Sexual Orientation <input type="checkbox"/> National Guard/Veteran <input type="checkbox"/> Gender Identity/Expression	
What remedy or resolution are you seeking?	

