Charge of Discrimination Form

Name

Home Phone Number

Address

Job Title

City

State

Zip Code

Indicate the person or persons who discriminated against you. (If more than one, list on Page 2 of this form.)

Name

Work Phone Number

Work Address

Job Title

City

State

Zip Code

Cause of discrimination is based on (check the appropriate boxes).

☐ Race

☐ Age

☐ Color

☐ Sex

☐ Sexual Orientation

☐ Gender

☐ Religion

☐ National Origin

☐ Religious Creed

☐ Ancestry

☐ Gender Identity

☐ Breastfeeding

☐ Veteran Status

☐ Political Affiliation

☐ Medical Condition

☐ Genetic Information

☐ Pregnancy-Related Condition

☐ Physical or Mental Disability

☐ Marital Status Unrelated to Job Requirements

☐ Other (please specify)

Date of most recent act of discrimination (month, day, year)

Date:
Indicate the remedy you seek.

Give a concise statement on how you have been discriminated against.

I declare that the above charge is true to the best of my knowledge, information and belief.

Signature __________________________ Date __________

Please note that failure to complete and submit a Charge of Discrimination Form shall not preclude an inquiry/investigation.