

**DISCRIMINATION COMPLAINT FORM
LOCAL WORKFORCE DEVELOPMENT AREA**

This form should be used by anyone who wishes to file a discrimination complaint against any person(s)/entity that discriminates against you in the workforce development community system. To file a discrimination complaint, complete this form, sign on page 4 and send to the Office of Economic and Workforce Development, Mr. Alfredo Fajardo, 1 South Van Ness Avenue, 5th Floor, San Francisco, CA 94103

1. Complainant Information

Miss Ms. Mrs. Mr. Other

Home Phone: _____

Work Phone: _____

Name: _____

Street Address: _____

City/State/Zip Code: _____

Email: _____ Cell: _____

2. Complainant Contact Information

When is it a convenient time during business hours (8am to 5pm) to contact you by phone about this complaint?

Day	Monday	Tuesday	Wednesday	Thursday	Friday
Time					
Phone					

3. Contact Information for the Person(s) Who You Claim Discriminated Against You

Provide the name of the entity where person(s) work(s):

Name of person(s) who discriminated against you: _____

Address of person(s)/entity: _____

City/State/Zip Code: _____

Phone: _____

Date of first occurrence: _____ Date of most recent occurrence: _____

4. Tell Us About the Incident(s)

- Explain briefly what happened and how you were discriminated against.
- Provide the date(s) when the incident(s) occurred.
- Indicate who discriminated against you. Include the names and titles if possible.
- If other people were treated differently than you, tell us how they were treated differently.
- Attach any documents that you think might help us better understand your complaint.

5. Please list below any person(s) (witnesses) that we may contact for additional information. To support or clarify the complaint

Name	Address	Phone

6. Basis for the Discrimination

Check the type of discrimination you experienced, such as age, race, color, national origin, disability, etc. If you believe more than one basis was involved, you may check more than one box.

- | | |
|--|--|
| <input type="checkbox"/> Age – <i>provide date of birth</i>
<input type="checkbox"/> Color
<input type="checkbox"/> National Origin
<input type="checkbox"/> Political Belief
<input type="checkbox"/> Gender – <i>Specify</i> _____
<input type="checkbox"/> Status as a program participant under the Workforce Innovation and Opportunity Act of 2014 (WIOA)
<input type="checkbox"/> Of Hispanic or Latino Origin
<input type="checkbox"/> Not of Hispanic or Latino Origin | <input type="checkbox"/> Citizenship or status as alien US Worker
<input type="checkbox"/> Disability
<input type="checkbox"/> Political Affiliation
<input type="checkbox"/> Religion
<input type="checkbox"/> Race – <i>indicate race</i> _____
<input type="checkbox"/> Sexual Harassment
<input type="checkbox"/> Other - (<i>Specify</i>) _____ |
|--|--|

7. Have you previously filed a complaint against this person(s)/entity? YES NO

If YES, answer the questions below, if NO move to section 8.

- a. Was your complaint in writing? Yes No
- b. On what date did you file the complaint? _____
- c. Name of Office where you filed your complaint: _____
Address: _____
City/State/Zip Code: _____
Phone number: _____ Contact Person (if known): _____
- d. Have you been provided a final decision or report? Yes No

If you marked "YES", please attach a copy of the complaint.

8. What corrective action or remedy do you seek? Please explain.

9. Choosing a personal representative

- You may choose to have someone else represent you in dealing with this complaint. It may be a relative, friend, union representative, an attorney, or someone else.
- If you choose to appoint someone to represent you, all of your communication to you will be routed through your representative

Do you want to authorize a personal representative to handle this complaint? Yes No

If YES, complete the section below. If NO, go to Section 10.

AUTHORIZATION OF PERSONAL REPRESENTATIVE

I wish to authorize the individual identified below to act on my behalf as my personal representative, in matters such as mediation, settlement conferences, or investigations regarding this complaint.

Name: _____

I am an attorney representing the complainant I am not an attorney representing the complainant

Mailing Address: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Signature of Authorized Personal Representative for Complainant

10. Alternate Dispute Resolution (ADR) also known as mediation

Notice – You **must** indicate if you wish to mediate your case. The EEO Office cannot begin to process your complaint until you have made a selection. Please check **YES** or **NO** in the spaces below.

- Mediation is an alternative to having your complaint investigated.
- Neither party loses anything by mediating.
- The parties to the complaint review the facts, discuss opinions about the facts, and strive for an agreement that is satisfactory for both
 - Agreement to mediate is not an admission of guilt by the person(s)/entity that you claim discriminated against you.
 - Medication is conducted by a trained, qualified and impartial mediator.
 - You (or your Personal Representative) have control to negotiate a satisfactory agreement.
 - Terms of the agreement are signed by the complainant and the person(s)/entity that you claim discriminated against you.
 - Agreements are legally binding on both parties.
 - If an agreement is not reached, a formal investigation will start.
 - Failure to keep an agreement will result in a formal investigation.
 - A formal investigation will be opened if retaliation is reported.
- **Do you wish to mediate your complaint?**
(Please check only one box)

YES, I want to mediate

NO, please investigate

If you select “YES” you will be contacted within five business days with more information

11. Complainant’s signature

You must sign this form for your complaint to be processed!

- Faxed or otherwise electronically delivered complaints will be logged into our system. However, an official investigation cannot begin until the original, signed copy is received.

Signature:

Date: