



Date Rec'd:

Case No.

COMPLAINT FORM

Name: _____ Address: _____ City & Zip: _____ Telephone: _____	Cause of Discrimination (check one): <input type="radio"/> Race <input type="radio"/> Color <input type="radio"/> National Origin <input type="radio"/> Disability <input type="radio"/> Religion <input type="radio"/> Age <input type="radio"/> Sex <input type="radio"/> Income
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Who discriminated against you:
Name: _____
Title: _____
Employer: _____

Explain the problem:

What would be a reasonable settlement of your charge:

I swear that the charge as listed is true to the best of my knowledge, information and belief.

(Signature) _____ (Date) _____

(County) _____ (State) _____

SUBSCRIBED AND SWORN TO before me this _____ day of _____ 20_____.