STAFF PERSONNEL

Series 400

POLICY TITLE ANTI-BULLYING/HARASSMENT COMPLAINT FORM No. 401.1E1

Date of complaint:	_____
Name of Complainant:	_____
Are you filling out this form for yourself or someone else (please identify the individual if you are submitting on behalf of someone else):	_____ _____
Who or what entity do you believe discriminated against, harassed, or bullied you (or someone else)?	_____
Date and place of alleged incident(s):	_____ _____
Names of any witnesses (if any):	_____

Nature of discrimination, harassment, or bullying alleged (check all that apply):

	Age		National Origin
	Disability		Race
	Color		Religion
	Creed		Sex
	Gender Identity		Sexual Orientation
	Genetic Information		Other-Please Specify:

In the space below, please describe what happened and why you believe that you or someone else has been discriminated against, harassed, or bullied. Please be as specific as possible and attach additional pages if necessary.

_____

_____

I agree that all of the information on this form is accurate and true to the best of my knowledge.

Signed _____Dated_____

Submit to: Human Resource Department

Date Approved: October 9, 2017