

STAFF PERSONNEL

Series 400

POLICY TITLE DISCRIMINATION INCLUDING DISCRIMINATORY HARASSMENT COMPLAINT FORM  
No. 401.1E4

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):

<input type="checkbox"/>	Age	<input type="checkbox"/>	National Origin
<input type="checkbox"/>	Disability	<input type="checkbox"/>	Race
<input type="checkbox"/>	Color	<input type="checkbox"/>	Religion
<input type="checkbox"/>	Creed	<input type="checkbox"/>	Sex
<input type="checkbox"/>	Gender Identity	<input type="checkbox"/>	Sexual Orientation
<input type="checkbox"/>	Genetic Information	<input type="checkbox"/>	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.

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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