

**COMPLAINT OF ALLEGED DISCRIMINATION FORM**

**Complainant Information:**

Please complete every appropriate item and submit it as soon as possible after the incident of alleged discrimination or harassment to:

OFFICE OF EQUAL OPPORTUNITY  
E.O. Complaint Unit  
65 Court Street, Room 923  
Brooklyn, NY 11201  
Phone #: 718-935-3320  
Fax #: 718-935-2531

➤ **A complaint must be filed within one year of the event which is the subject of the complaint.**

➤ Please **print clearly** all requested information.

➤ Also attach additional pages and supporting documentation, if necessary.

Check () One:       Employee       Student       Parent       Applicant for Employment

Name: \_\_\_\_\_ Title: \_\_\_\_\_

\*Student's Name: \_\_\_\_\_  
(\*If complaint is being filed by parent)

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**Head of Site Information:**

Name of Principal or Head of Site: _____
Title: _____
School/Office/District: _____
Site Address: _____
Site Phone#: _____

(over)

**Nature of Complaint**

1. Check  below why you believe you were discriminated against.

- |  |  |
|--|--|
| <input type="checkbox"/> Age                         | <input type="checkbox"/> Partnership Status  |
| <input type="checkbox"/> Alienage/Citizenship Status | <input type="checkbox"/> Predisposing Genetic Characteristic                                     |
| <input type="checkbox"/> Arrest/Conviction           | <input type="checkbox"/> Race  |
| <input type="checkbox"/> Color                       | <input type="checkbox"/> Religion  |
| <input type="checkbox"/> Creed                       | <input type="checkbox"/> Retaliation (for asserting a claim of discrimination)                   |
| <input type="checkbox"/> Disability                  | <input type="checkbox"/> Sexual Harassment   |
| <input type="checkbox"/> Ethnicity/National Origin   | <input type="checkbox"/> Sexual Orientation  |
| <input type="checkbox"/> Gender/Sex                  | <input type="checkbox"/> Status as a Victim of Domestic Violence, Sexual Offenses<br>or Stalking |
| <input type="checkbox"/> Marital Status              |  |
| <input type="checkbox"/> Military Status             |  |

2. Name(s)/title(s) of person(s) you believe discriminated against you.

1. Name: _____	1. Title: _____	2. Name: _____	2. Title: _____
3. Name: _____	3. Title: _____	4. Name: _____	4. Title: _____

3. Where did it take place?

\_\_\_\_\_

4. Date(s) on which alleged act(s) of discrimination occurred.

Month: \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_      Month: \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Month: \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_      Month: \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

5. Explain what happened (cite names and evidence, if any, and attach extra pages if needed).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. What relief or corrective action are you seeking?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_