





# CIVIL RIGHTS DISCRIMINATION COMPLAINT

USE AN ADDITIONAL SHEET OF PAPER TO ANSWER ANY QUESTION IF NECESSARY.

1. NAME (Last, First, Middle Initial) (Please print)	2. MAILING ADDRESS	3A. WORK TELEPHONE NO. (Include area code)
		3B. HOME TELEPHONE NO. (Include area code)

4. NAME AND ADDRESS OF VA FACILITY OR OTHER AGENCY WHERE DISCRIMINATION OCCURRED.	5. NAME OF SERVICE/PRODUCT LINE WHERE DISCRIMINATION OCCURRED.	6. NAME OF INDIVIDUAL (If known) WHO DISCRIMINATED (Include phone number) OR IDENTIFY THE DISCRIMINATORY PRACTICE.
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**INSTRUCTIONS:** For each claim you believe was discriminatory, list the bases for your complaint: (List one or more): Race (Specify), Color (Specify), Sex (Male, Female), National Origin(Specify), Age (Provide date of birth), Disability (Physical/or Mental)

7. BASIS <input type="checkbox"/> RACE <input type="checkbox"/> COLOR <input type="checkbox"/> SEX (Male or female) <input type="checkbox"/> NATIONAL ORIGIN <input type="checkbox"/> AGE (Date of birth) <input type="checkbox"/> DISABILITY	8. DATE OF DISCRIMINATION (Include the most recent date(s))
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9. ISSUE(S) (If your complaint concerns discrimination in the delivery of services, or employment, briefly describe what happened below.)

10. LIST THE MOST CONVENIENT TIME AND PLACE FOR YOU TO BE CONTACTED REGARDING THIS COMPLAINT:	11. PLEASE PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ATTORNEY OR REPRESENTATIVE (If applicable).
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12. IF THE DISCRIMINATORY ACT IN WHICH YOU DESCRIBED ABOVE OCCURRED MORE THAN 180-DAYS AGO, PLEASE EXPLAIN WHY YOU WAITED UNTIL NOW TO FILE A COMPLAINT.

13. LIST ANY PERSON (Witness, fellow employee) WHO CAN SUPPORT YOUR ALLEGATION (List name, address, telephone number)	14. HAVE YOU FILED THIS COMPLAINT WITH ANOTHER AGENCY? (If yes, provide the name and address) <input type="checkbox"/> YES <input type="checkbox"/> NO
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15. WHAT REMEDY ARE YOU SEEKING FOR THE ALLEGED DISCRIMINATION LISTED ABOVE?

16. SIGNATURE OF COMPLAINANT (Do not print)	17. DATE
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