Title VI, ADA and EEO Complaint Form

Any individual may exercise their right to file a complaint if that person believes that they have been subjected to unequal treatment or discrimination in the receipt of benefits or services or in employment. CLB will make a concerted effort to resolve complaints at the lowest level possible.

Please complete this form to the best of your ability. If you need translation or other assistance, contact the human resources department. Please print if you are not completing this form electronically.

Name_____

Address_____City_____Zip_____

Phone: Home_____ Work_____ Mobile_____

Email: _____

Basis of Complaint (mark all that apply):

Race	Color	Religion	National Origin
Sex/Gender	Sexual Orientation	Gender Identity	Age
Disability	Retaliation	Other, please specify:	

Who discriminated against you?

Name_____
Name of Organization_____
Address_____ City_____ Zip_____
Telephone_____

How were you discriminated against? (Attach additional pages if more space is needed)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
_____
_____
_____

Where did the discrimination occur?

_____
_____
_____

Dates and times discrimination occurred?

_____
_____
_____
_____
_____

Were there any other witnesses to the discrimination?

Name
Organization/Title
Work Telephone
Home Telephone

Name
Organization/Title
Work Telephone
Home Telephone

How would you like to see this situation resolved?

_____
_____
_____
_____
_____

Have you filed your complaint, grievance, or lawsuit with any other agency or court?

Who _____ When _____
Status (pending, resolved, etc.) _____ Result, if known _____
Complaint number, if known _____

Do you have an attorney in this matter?
Name_____ Phone_____

Address_____ City_____ Zip_____

I affirm that I have read the above complaint and that it is true to the best of my knowledge, information and belief.

Complainant Name: _____

Signature: _____Date_____