James Monroe Building
101 N. 14th Street, 12th Floor
Richmond, Virginia 23219
(804) 225-2136
FAX: 804-371-7401
eescvs@dhrm.virginia.gov

Commonwealth of Virginia

Department of Human Resource Management
Office of Workforce Engagement

NOTICE OF APPEAL - COMPLAINANT

1.	**Complainant Information:**					
	Name:					
	Mailing Address:					
	City, State, and Zip Code:					
	Home Telephone:		**Business Telephone:**		**Day Telephone:**	
	Work Email:					
	Personal Email:					
2.	**Attorney Information (if any):**					
	Attorney Name:					
	Street Address:					
	City:					
	State, Zip Code:					
	Telephone Number:		**Email:**			
3.	**Agency whose final decision you are appealing:**					
	Agency:					
	Street Address:					
	City:					
	State, Zip Code:					
	Telephone Number:		**Agency's Complaint Number:**			
4.	**Agency personnel against whom who you are filing an appeal:**					
A.	**Person One:**	**Name:**		**Title:**		
B.	**Person Two:**	**Name:**		**Title:**		
C.	**Person Three:**	**Name:**		**Title:**		
5.	**Has a final decision been made by your agency about this matter?**					
	Yes ☐ **No** ☐					
	If "**Yes**", please indicate the date you received the final decision. **Remember to attach a copy.**	**Date Final Decision Received:**				

6.	**Check all boxes that apply to the act(s) of discrimination that you filed with your agency.**
☐	**A. Age** (You are 40 years of age or older. **Please indicate your age**)
☐	**B. Color** (**Please indicate your color**):
☐	**C. Disability**
☐	**D. Genetic Information** (Your family medical history or participation in genetic services like counseling, education, or testing.)
☐	**E. National Origin and/or Ethnicity** (**Please indicate)**
☐	**F. Political Affiliation** (**Please indicate your political party**)
☐	**G. Race** (Please identify the racial group(s) which you identify yourself as) ☐ **a. White** ☐ **b. Black or African American** ☐ **c. Asian** ☐ **d. Hispanic** ☐ **e. American Indian or Alaskan Native** ☐ **f. Native Hawaiian or Pacific Islander** ☐ **g. Two or more**
☐	**H. Religion** (Please indicate your belief system.)
☐	**I. Sex** ☐ **Male** ☐ **Pregnancy** ☐ **Female** ☐ **Sexual Harassment** ☐ **Gender Identity** ☐ **Non-Binary** ☐ **Sexual Orientation** ☐ **Gender Expression**
☐	**K. Veterans Status**
☐	**J. Retaliation** (Please select those that apply to your appeal.) ☐ You filed a complaint of discrimination about any of the above. ☐ You contacted a government agency to complain about job discrimination. ☐ You complained to your employer about job discrimination. ☐ You helped or was a witness in someone's complaint about job discrimination.
7.	**Describe the relief that you are seeking:**
8.	**Have you filed a grievance about this matter with the DHRM Office of Employment Dispute Resolution?**
	Yes ☐ **No** ☐ If "**Yes**", please provide a copy of grievance Form A and all associated documents and indicate the status of your grievance)

9.	**Have you filed a complaint with the EEOC about this matter?**				
	Yes ☐ **No** ☐				
	If "**Yes**", please provide your case number:				
10.	**Have you filed a complaint with another agency about this matter?**				
	Yes ☐ **No** ☐				
	If "**Yes**", complete ***a*** through ***c*** below				
	a.	**Agency**:		**Contact Person:**	
	b.	**Address**:			
		City, State, and Zip Code:			
	c.	**Telephone Number:**		**Date Filed:**	
11.	**Have you filed a lawsuit about this matter?**				
	Yes ☐ **No** ☐				
	If "**Yes**", complete ***a*** and ***b*** below.				
	a.	**Name of Court**:			
	b.	**Case Docket Number**:		**Date Filed:**	
12.	**Attorney Information related to question 11 – If different from attorney information in question 2:**				
	Attorney Name:				
	Street Address:				
	City:				
	State, Zip Code:				
	Telephone Number:			**Email:**	

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

By submitting this form, I understand that an investigation will commence if the appeal is accepted and the agency that the appeal is filed against will be notified. I agree to cooperate with the investigation. I understand that the Office of Workforce Engagement's Diversity, Equity, and Inclusion Unit will request the agency which this appeal is filed against to release any and all personnel records, including but not limited to, medical records, deemed necessary to complete this investigation. Documents will only be shared with respect to the investigation and the performance of these duties.

This NOTICE OF APPEAL - COMPLAINANT form must be filed within 15 calendar days of the date of your agency's final decision upon which this appeal is based. The date the appeal is filed is the date on which it is postmarked, hand delivered, submitted, or faxed to the DHRM address above.

Signature: _____ Date: _____

FILING WITH THIS OFFICE DOES NOT PRECLUDE YOU FROM FILING WITH THE U.S. FEDERAL EQUAL EMPLOYMENT OPPORTUNITY COMMISSION OR OTHER FEDERAL AGENCIES.