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Commonwealth of Virginia

Department of Human Resource Management

Office of Workforce Engagement

DISCRIMINATION COMPLAINT FORM

1.	**Individual filling the complaint**					
	Name:					
	Address:					
	City/Town or County, State, and Zip Code:					
	Home Telephone:		**Business Telephone:**		**Day Telephone:**	
	Work Email:					
2.	**Agency and individual that you believe committed the act(s) of discrimination**					
	Agency name:					
	Name of individual:					
	Agency at which you are employed, if different from above:					
3.	**You believe you were discriminated against base on:** (Check all boxes that apply to the **acts of discrimination**)					
	☐	**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** (Including pregnancy, sexual harassment, sexual orientation, and gender identity and expression.) **Male** ☐ **Female** ☐ **Non-Binary** ☐				

	☐	**J. Veteran Status**
	☐	**K. Retaliation** (Please select those that apply to your complaint.) ☐ 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

4.	**Briefly describe why you believe that you have been discriminated against.** (Please include names, telephone numbers, and job titles of all persons involved in the discriminatory acts you describe. Attach additional pages if needed.)
5.	**Describe when the discriminatory acts occurred:**
	When did the discriminatory acts occur? (Provide month, day, year.)
6.	**Describe the relief that you are seeking:**
7.	**Have you filed a grievance about this matter?**
	Yes ☐ **No** ☐ If "**Yes**", please provide a copy of grievance Form A and all associated documents and indicate the status of your grievance)
8.	**Have you filed a complaint with the EEOC about this matter?**
	Yes ☐ **No** ☐
	If "**Yes**", please provide your case number:
9.	**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:**	

10.	**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:**	

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 complaint is accepted and the agency that the complaint is filed against will be notified. I agree to cooperate with the investigation. I understand that the Office of Workforce Engagement will request the agency which this complaint 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.

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.