

PRELIMINARY INTAKE FORM

This form will provide preliminary information to the Charge Intake Coordinator in order to assist in the interview and charge filing process. You will be contacted within 24 hours of submitting this form.

Your Name:		
Street:		City:
State:	Zip:	County:
Home Phone:		Work Phone:
Email Address:		Cell Phone:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Age: Date of Birth:
Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Other _____		National Origin: <input type="checkbox"/> American <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Other _____

Provide the name of the State or County Government Agency you believe discriminated against you:

Name of the Agency:		
Street:		City:
State:	Zip:	County:
Agency's telephone no. (with area code):		
Most recent date of alleged harm (that you believe was discrimination) to you:		
Do you think this happened to you because of your (check as appropriate): <input type="checkbox"/> Race <input type="checkbox"/> Sex <input type="checkbox"/> National Origin <input type="checkbox"/> Disability <input type="checkbox"/> Age (40 & over) <input type="checkbox"/> Color <input type="checkbox"/> Religion <input type="checkbox"/> Pregnancy <input type="checkbox"/> Retaliation <input type="checkbox"/> Sexual Harassment <input type="checkbox"/> Other _____		
In your own words, briefly describe what happened to you that you believe to be discriminatory. A short description of what happened will be enough at this time.		

**** By completing this form you have not filed a charge of employment discrimination. ****