PUBLIC ACCOMMODATIONS DISCRIMINATION COMPLAINT QUESTIONNAIRE

PROFESSIONAL STANDARDS/HUMAN RIGHTS SECTION
115 S. ANDREWS AVENUE, ROOM 427
FORT LAUDERDALE, FLORIDA 33301
TELEPHONE: (954) 357-6500 FAX: (954) 357-7817 TTY (954) 357-7888

IMPORTANT NOTICE TO POTENTIAL COMPLAINANT: Completion of this form is necessary in order for the Professional Standards/Human Rights Section (Section) to determine if you have sufficient legal grounds to initiate the filing of a complaint of public accommodations discrimination.

Completion and submission of this questionnaire does not constitute the filing of a complaint of discrimination.
Upon receipt of the completed questionnaire, we will determine if you have stated sufficient factual allegations to proceed further. If the facts are not sufficient, we will either contact you for further information or notify you of our determination that the facts are not sufficient. If the facts are sufficient, a complaint will be prepared for you to sign, notarize and return to the Section for filing and investigation. You must return the signed and notarized complaint document so that it is received by the Section within 365 days of the date of the most recent act of alleged discrimination.

When completing this form, please print legibly or use a typewriter.
Please do not write on the back of the page. Use additional sheets if necessary.

1. PERSONAL INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Street/Mailing Address: _____ Apt./Unit # _____

City: _____ County: _____ State: _____ Zip: _____

Phone Numbers: Home: (____) _____ Work: (____) _____

Cell: (____) _____ Email Address: _____

Date of Birth: _____ Sex: Male ☐ Female ☐

National Origin/Ethnicity: _____ Do you have a disability? Yes ☐ No ☐

How did you hear of our office? _____

PROVIDE THE NAME OF A PERSON WE CAN CONTACT IF WE ARE UNABLE TO REACH YOU:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: (____) _____ Other: (____) _____

2. INFORMATION ABOUT YOUR DISCRIMINATION CLAIM:

What is the name of the Public Accommodations provider that you believe discriminated against you?

Name: _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____ Telephone: _____

The person named above operates a business, which serves the public. The type of business is:

- ☐ An inn, hotel, motel or other establishment providing lodging.
- ☐ A restaurant, bar, cafeteria, lunchroom, lunch counter, soda fountain or other facility principally engaged in selling food for consumption on the premises.
- ☐ A gasoline station.
- ☐ A movie theater, performance venue, concert, sports arena, stadium or other place of exhibition or entertainment.
- ☐ Other: _____

3. WHAT IS THE REASON (BASIS) FOR YOUR CLAIM OF PUBLIC ACCOMMODATIONS DISCRIMINATION?

EXAMPLE: Were you denied dining services because of your race? Were you turned down lodging because of your gender? Were you subjected to different terms and conditions? Check the factor(s) below that you believe apply.

Note: If your claim is based on disability, please complete questions 12 – 16 located on page 4.

Race ☐ Color ☐ National Origin ☐ Sex ☐ Age ☐ Religion ☐ Disability ☐ Pregnancy ☐

Gender Identity/Expression ☐ Sexual Orientation ☐ Political Affiliation ☐ Marital Status ☐

Retaliation ☐

4. BRIEF STATEMENT REGARDING YOUR DISCRIMINATION CLAIM:

The most recent act of discrimination took place on: _____

(**Month**) (**Day**) (**Year**)

(Briefly describe the action that was taken against you that you believe to be discriminatory and why you believe the action was discriminatory. Indicate what harm, if any, was caused to you and/or others in your party or family, as a result of this alleged action. **Use additional sheets if necessary. Please do not write on the reverse side of the page.**

5. **WHAT REASON(S), IF ANY, DID THE PUBLIC ACCOMMODATIONS PROVIDER GIVE FOR THE ALLEGED DISCRIMINATORY TREATMENT?**

6. **ARE THERE ANY WITNESSES TO THE ALLEGED DISCRIMINATORY INCIDENT(S)?** Yes ☐ No ☐ If yes, please provide the names, addresses and contact numbers for all persons who have knowledge about the alleged discriminatory treatment and indicate what each person knows about this matter**.**

7. **WHAT RELIEF ARE YOU SEEKING IN THIS MATTER OR WHAT WOULD YOU BE WILLING TO ACCEPT TO RESOLVE THIS MATTER IMMEDIATELY?**

8. **ARE YOU WILLING TO PARTICIPATE IN MEDIATION TO SEEK AN EARLY RESOLUTION OF YOUR CLAIM(S)?**

   Yes ☐ No ☐

9. **HAVE YOU SOUGHT ASSISTANCE FROM ANY OTHER AGENCY, ATTORNEY, ETC?** Yes ☐ No ☐ If yes, please provide the name of the person or organization you spoke with, the date of assistance and the results, if any

10. **HAVE YOU PREVIOUSLY FILED A COMPLAINT WITH THE HUMAN RIGHTS SECTION OR ANOTHER AGENCY?** Yes ☐ No ☐ If yes, when did you file?

    _____ Complaint No. (if known): _____
    (**Month**) (**Day**) (**Year**)

11. **ADDITIONAL COMMENT(S)**:

INFORMATION ABOUT YOUR DISABILITY: IF YOU ARE CLAIMING DISCRIMINATION BASED ON DISABILITY, PLEASE ANSWER THE FOLLOWING QUESTIONS:

12. **DO YOU (OR THE PERSON YOU ARE ASSISTING) HAVE A PHYSICAL OR MENTAL IMPAIRMENT?** Yes ☐ No ☐

13. WHAT IS THE NAME OF YOUR DISABILITY? HOW DOES YOUR DISABILITY AFFECT OR LIMIT YOUR DAILY LIFE OR WORK ACTIVITIES? (Example: lifting, sleeping normally, breathing normally, pulling, walking, climbing, caring for oneself, working, seeing, hearing, speaking, performing manual tasks, other, etc.)

14. IS YOUR DISABILITY PERMANENT? Yes ☐ No ☐ If no, how long is your disability expected to persist?

15. DO YOU BELIEVE THAT THE PUBLIC ACCOMMODATIONS PROVIDER KNOWS ABOUT YOUR DISABILITY? Yes ☐ No ☐

16. DID YOU REQUEST AN ACCOMODATION BECAUSE OF YOUR DISABILITY? Yes ☐ No ☐
If you answered yes, when did you make the request? Was it written or verbal? To whom did you make the request? What was the public accommodations provider's response to your request for an accommodation?

A. I have been advised by a representative of the Broward County Professional Standards/Human Rights Section (Section) that completion of this questionnaire is necessary in order for the Section to determine if I have sufficient legal grounds to initiate the filing of a complaint of public accommodations discrimination. I understand that completion and submission of this questionnaire does not constitute the filing of a complaint of public accommodations discrimination and that upon receipt and review of this completed questionnaire, the Section will determine if I have stated sufficient factual allegations to proceed with the actual filing of a complaint of public accommodations discrimination.

B. I understand that to be timely filed, a complaint of public accommodations discrimination must be signed and received by the Section within 365 days of the date of the most recent act of alleged discrimination.

Under penalty of perjury, I declare that I have read the entire contents of this questionnaire and that my answers and statements contained herein are true and correct.

Signed: _____

Printed Name: _____

Date Signed: _____