EMPLOYMENT DISCRIMINATION
HUMAN RIGHTS COMPLAINT QUESTIONNAIRE

PROFESSIONAL STANDARDS/HUMAN RIGHTS SECTION
115 S. ANDREWS AVENUE, SUITE 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 employment discrimination.

Completion and submission of this questionnaire does not constitute the filing of a complaint of discrimination. Upon receipt of this 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 reverse side 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:

I believe that I was discriminated against by the following employer/organization:

Employer's/Organization's Name: _____

Employer's/Organization's Address: _____ County: _____

City: _____ State: _____ Zip: _____

Type of Business: _____ Telephone: (____) _____

Number of employees in the organization: Please check **(✓)** one

Less than 15 ☐ 15 – 100 ☐ 101 – 200 ☐ 201 – 500 ☐ 501+ ☐

3. YOUR EMPLOYMENT DATA (*Complete as many items as you can*):

Date Hired: _____ Job Title at Hire: _____

Pay Rate When Hired: _____ Last/Current Pay Rate: _____

Are you now employed by this employer? Yes ☐ No ☐ If you are no longer employed, did you resign or were you terminated? _____

If you resigned or were terminated, when did you last work for this employer? _____

Job title at time of alleged discrimination: _____

Name and title of immediate supervisor: _____

If an applicant, date you applied for job: _____ **Job applied for**: _____

4. WHAT IS THE REASON (BASIS) FOR YOUR CLAIM OF EMPLOYMENT DISCRIMINATION?

*EXAMPLE: If you are over the age of 40 and feel you were treated worse than younger employees **or** you have other evidence of discrimination, you should check **(✓) AGE**. If you feel that you were treated worse than those not of your race **or** you have other evidence of discrimination, you should check **(✓) RACE**. If you feel the adverse treatment was due to multiple reasons, such as your sex, religion and national origin, you should check all three. If you complained about discrimination, participated in someone else's complaint or if you filed a complaint of discrimination and a negative action was threatened or taken, you should check **(✓) RETALIATION**.*

***Note: If your claim is based on disability, please complete questions 15 – 18 located on page 4**.*

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

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

5. 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 or others in your work situation as a result of this alleged action. For example, were you fired, not promoted, not hired, laid off, paid different wages, harassed, etc.) **Use additional sheets if necessary. Please do not write on the reverse side of this page.**

7. WHAT REASON(S) WAS GIVEN TO YOU FOR THE ACTS YOU CONSIDER DISCRIMINATORY? BY WHOM? TITLE?

8. DURING MY EMPLOYMENT, I ☐ DID ☐ DID NOT RECEIVE ANY DISCIPLINARY ACTIONS. IF DISCIPLINARY ACTIONS WERE RECEIVED, PLEASE PROVIDE THE TYPE OF DISCIPLINARY ACTION AND THE DATE.

9. NAME AND DESCRIBE OTHERS WHO WERE IN THE SAME SITUATION AS YOU. EXPLAIN ANY SIMILAR OR DIFFERENT TREATMENT. WHO WAS TREATED WORSE, WHO WAS TREATED BETTER AND WHO WAS TREATED THE SAME? IDENTIFY EACH INDIVIDUAL BY NAME, RACE, SEX, AGE, NATIONAL ORIGIN, ETC. AS APPROPRIATE.

10. 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.

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

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

Yes ☐ No ☐

13. 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.

14. HAVE YOU PREVIOUSLY FILED A COMPLAINT WITH THE SECTION OR EEOC? Yes ☐ No ☐ If yes, when did you file?

_____

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

INFORMATION ABOUT YOUR DISABILITY

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

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

16. 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.)

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

18. DID YOU ASK YOUR EMPLOYER FOR AN ACCOMMODATION IN WORKING CONDITIONS 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 employer'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 employment discrimination. I understand that completion and submission of this questionnaire does not constitute the filing of a complaint of employment 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 employment discrimination.

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

C. I have been given assurances by an agent of the Section that pursuant to Broward County's Human Rights Ordinance (Chapter 16 ½), and applicable Florida Statutes, this Questionnaire will be considered confidential and will not be disclosed (except to the parties to this proceeding, including the employer and its legal representative) as long as the case remains open, unless it becomes necessary for the Section to produce the Questionnaire in a formal proceeding. Upon the closing of this case, the Questionnaire may be subject to further disclosure in accordance with Chapter 16 ½ and Florida's Public Record Act.

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: _____