

MARYLAND DEPARTMENT OF HUMAN RESOURCES

Office of Employment and Program Equity

311 W. Saratoga Street, Room 199

Baltimore, Maryland 21201-3521

CUSTOMER COMPLAINT OF DISCRIMINATION

Complainant Information

Name: _____ Telephone: (w)____ - _____ (h) ____ - _____

Race: _____ Gender: _____

Home Address: _____
No., Apt., Street

City, State, Zip Code

Agency Name: _____

Caseworker Name: _____ Phone Number: _____

Respondent/ Violator Information

Name: _____ Title: _____

Race: _____ Gender: _____

Date(s) of Alleged Act(s) of Discrimination: _____ Continuing? (Y) (N)

DISCRIMINATION MUST BE BASED ON ONE OR MORE OF THE FOLLOWING. PLEASE CHECK ALL THAT APPLY. AN INCOMPLETE FORM MAY RESULT IN DELAYS.

Basis (check all that apply)

age___ ancestry___ color___ disability: mental___ physical___ marital status___ sex___

religion___ race___ creed___ national origin___ sexual harassment___ retaliation___

gender identity/expression___ genetic information___ sexual orientation___

Print Your Name _____

WITNESSES- Information obtained from this investigation is confidential and OEPE will only share when it is in the best interest of DHR to do so. Please list any Witnesses to the event(s).

Name: _____ Title: _____
Telephone: _____ Email Address: _____
Describe what s/he observed in connection to your complaint: _____

Name: _____ Title: _____
Telephone: _____ Email Address: _____
Describe what s/he observed in connection to your complaint: _____

Name: _____ Title: _____
Telephone: _____ Email Address: _____
Describe what s/he observed in connection to your complaint: _____

Remedies

Briefly describe what kind of remedy you are seeking. What do you want to happen as a result of filing this complaint?

I hereby certify that the information I have provided is true to the best of my knowledge and/or recollection.
Signed: _____ Date: _____
Print Name: _____