



EMPLOYMENT INTAKE QUESTIONNAIRE

**COMPLETING THIS INTAKE QUESTIONNAIRE DOES NOT CONSTITUTE THE FILING
OF A DISCRIMINATION CHARGE.**

***Required Fields**

1. COMPLAINANT	
*Today's Date: _____	*Name: _____
*Address: _____	*City/State/Zip: _____
E-mail: _____	*What language do you prefer to communicate in? ___ English ___ Spanish ___ Amharic ___ Chinese ___ Vietnamese ___ Korean ___ Other (Please list) _____
*Home Tel #: _____	
Work Tel #: _____	
IF REPRESENTED BY COUNSEL, PLEASE PROVIDE THE FOLLOWING:	
Name: _____ Telephone/Fax: _____ E-mail: _____ Address: _____	
<small>Please note: If you are represented by counsel or retain counsel prior to your scheduled Intake interview, the counsel must either (1) be present with you for the duration of your Intake interview, or (2) withdraw his/her appearance from the interview by submitting a letter to the Office indicating that the interview may take place without his/her representation.</small>	
Do you require a reasonable accommodation? If so, please explain: _____	
Do you require language interpretation? If so, what language? _____	
2. RESPONDENT	
Name of company or organization: _____	
Name and Title of principal officer (i.e. President, Owner, Human Resources Manager): _____	
Address _____	City/State/Zip _____
Tel #: _____	Fax #: _____ E-mail Address: _____
3. BASIS OF COMPLAINT	
The basis is one of the below listed categories to which you belong and believe that you were treated differently because you belong or are perceived to belong in that category.	
*Do you feel you were discriminated against because of your: (Please check appropriate box).	
<input type="checkbox"/> Race	<input type="checkbox"/> Sex
<input type="checkbox"/> Political Affiliation	<input type="checkbox"/> Disability
<input type="checkbox"/> National Origin	<input type="checkbox"/> Religion
<input type="checkbox"/> Age	<input type="checkbox"/> Genetic Information
<input type="checkbox"/> Family Responsibilities	<input type="checkbox"/> Gender Identity or Gender expression
<input type="checkbox"/> Personal Appearance	<input type="checkbox"/> Color
<input type="checkbox"/> Sexual Orientation	<input type="checkbox"/> Marital Status
<input type="checkbox"/> Matriculation	
4. JURISDICTION	
*Please check all that apply:	
<input type="checkbox"/> Alleged violation occurred in the District of Columbia.	
<input type="checkbox"/> Alleged violation occurred 365 days or less from today's date.	
<input type="checkbox"/> You have not commenced any other action, civil, criminal, or administrative in any other forum based on the same unlawful discriminatory practice described herein.	

5. ISSUES

*What action was taken that made you feel you were treated differently?

- Family Medical Leave Promotion Transfer Demotion
- Retaliation Sexual Harassment Hostile Work Environment Failure to Hire
- Discharge Discipline Failure to Accommodate (i.e. Religion, Disability)
- Other: _____

6. DISTRICT OF COLUMBIA GOVERNMENT EMPLOYEES OR APPLICANTS

Please note: Pursuant to §105 of DCMR Title IV, all District Government employees must first consult an agency EEO counselor within 180 days of the alleged discriminatory act prior to filing with the Office of Human Rights, *unless* the District Government employee is alleging unlawful discrimination based on sexual harassment. The Office of Human Rights cannot process a complaint from a current of former District Government employee unless (1) the employee has received an exit letter from his/her agency EEO Counselor; (2) twenty-one days have passed since the matter was called to the attention of the agency's EEO counselor and no exit letter has been written; or (3) the employee is alleging unlawful discrimination based on sexual harassment.

You have filed an informal complaint with an agency assigned EEO Officer/ Counselor.

Counselor's Name: _____

Counselor's Agency: _____

Counselor's Telephone Number: _____

Date Filed: _____ Date of Exit Letter: _____

7. D.C. FAMILY AND MEDICAL LEAVE ACT

(Only complete section if your complaint deals with FMLA.)

*Have you been employed with this company for at least one (1) year and have worked at least one thousand (1,000) hours?

YES NO

8. WITNESSES

List whom you feel can corroborate your experience and provide evidence in your support.

Name: _____

Name: _____

Name: _____

E-mail Address: _____

E-mail Address: _____

E-mail Address: _____

Telephone: _____

Telephone: _____

Telephone: _____

*9. YOUR COMPLAINT

Describe in detail the incident(s) that led you to file a complaint of discrimination. Please list dates as well as the name(s) of the person(s) who discriminated against you in denying employment, promotion, training, etc. If this is a disability-based complaint, please specify whether an accommodation was requested; the person the request was submitted to and the date Respondent was notified of your disability.

SUBMITTING THIS INTAKE QUESTIONNAIRE DOES NOT CONSTITUTE THE FILING OF A CHARGE.

Please return this form by mail or in-person to: 441 4th Street NW, Suite 570N, Washington DC, 20001.

The DC Office of Human Rights was established to eradicate discrimination, increase equal opportunity and protect human rights for persons who live, work, or visit the District of Columbia. The receipt of this complaint form by the Office of Human Rights will lead to an intake interview.

*Signature of Potential Charging Party

*Date