



COUNTY OF SONOMA  
**HUMAN  
 RESOURCES  
 DEPARTMENT**

OPPORTUNITY ■ DIVERSITY ■ SERVICE

**Complaint Form**

FOR OFFICIAL USE ONLY		
Interview Date:		
Interviewer:		
Approval:		
Action Taken:		
Processing Time:	:HR	:MIN
Formal:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Informal:	YES <input type="checkbox"/>	NO <input type="checkbox"/>

The information requested on this form will assist EEO in the Complaint Process.

PLEASE PRINT

DATE:

**Complainant's Name:** \_\_\_\_\_  
First Middle Last

**Address:** \_\_\_\_\_  
Street Apt. # City County Zip Code

**Telephone Number:** **WORK:** ( ) \_\_\_\_\_ **HOME:** ( ) \_\_\_\_\_  
Area Code Area Code

Do you prefer to be contacted by telephone at work/home: Day(s): \_\_\_\_\_ Time: \_\_\_\_\_

Person to contact if you cannot be reached or if you move:

**Name:** \_\_\_\_\_ **Telephone #:** ( ) \_\_\_\_\_  
Area Code

**WHOM DO YOU WISH TO COMPLAIN AGAINST?:** (Name and address of individual, department etc.)

**Name:**

**Address:** \_\_\_\_\_  
Street City County Zip Code

**Telephone Number:** **WORK:** ( ) \_\_\_\_\_ **HOME:** ( ) \_\_\_\_\_  
Area Code Area Code

**OTHERS YOU WISH TO COMPLAIN AGAINST:** (Other named individuals who were involved in this particular complaint.)

**Name:**

**Title:** \_\_\_\_\_ **Telephone #:** ( ) \_\_\_\_\_  
Area Code

**Address:** \_\_\_\_\_  
(if known) Street City County Zip Code

(Continue on back if necessary)

1. On which basis do you believe you were discriminated against?: (Please check as many as apply.)

- Race       Age (40 and over)       National Origin       Religion
- Color       Sexual Orientation       Medical Condition       Cancer
- Sex       Marital Status       Pregnancy       Denial of Family Care Leave
- Genetic Characteristics       Disability       Ancestry
- Other \_\_\_\_\_

2. Check the alleged discriminatory conduct (and indicate the date of occurrence):

- \_\_\_\_\_ Terminated/Laid Off      \_\_\_\_\_ Denied Promotion      \_\_\_\_\_ Harassed
- \_\_\_\_\_ Denied Leave (Pregnancy/Family Care Leave)      \_\_\_\_\_ Denied Accommodation      \_\_\_\_\_ Retaliation
- \_\_\_\_\_ Denied Accommodation for Pregnancy      \_\_\_\_\_ Denied Equal Pay      \_\_\_\_\_ Not Hired
- \_\_\_\_\_ Impermissible Non-Job-Related Inquiry      \_\_\_\_\_ Other

3. List the names, addresses, job titles and telephone numbers (if possible) of witnesses, co-workers, or others you feel could provide information. Explain what you think each witness will be able to tell us.

Name and Address	Title/Relationship	Telephone Numbers	
		Home	Work

Can provide information regarding:

Name and Address	Title/Relationship	Telephone Numbers	
		Home	Work

Can provide information regarding:

(Use extra sheets of paper for additional witnesses, if necessary.)

4. Have you filed a complaint with the Department of Fair Employment & Housing (DFEH), or the U.S. Equal Employment Opportunity Commission (EEOC)? YES\_\_\_ NO\_\_\_ DFEH\_\_\_ EEOC

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

INTERVIEWER'S NOTES

Complainant's assertions:

Three horizontal lines for writing.

Relevant information:

Five horizontal lines for writing.

What does Complainant say the department's position will be?

Three horizontal lines for writing.

What does Complainant want as a remedy?

Three horizontal lines for writing.

Complaint taken for investigation?

YES\_\_ NO

If not taken, explain rationale:

Three horizontal lines for writing.

Did you inform Complainant of County Policy and time frames?

YES\_\_ NO

Did you give the Complainant a copy of County Policy?

YES\_\_ NO

Did you give the Complainant a copy of County Complaint Form?

YES\_\_ NO

Did you inform Complainant of other agencies (DFEH & EEOC)?

YES\_\_ NO

