

## Employment Complaints Form

### Background Information

Please fill in each field to the best of your ability and submit to the CHRC office.

1. Your Full name and address:

<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Name:	<input type="text"/>
Street Address:			<input type="text"/>	
City:			State:	<input type="text"/>
Zip Code:			<input type="text"/>	
Phone:			<input type="text"/>	
Email:			<input type="text"/>	

The following person always knows where to contact me:

Name:	<input type="text"/>		
Relationship to You:	<input type="text"/>		
Street Address:	<input type="text"/>		
Phone:	<input type="text"/>		
City:	State:	<input type="text"/>	
Zip Code:	<input type="text"/>		

2. Where are you employed now?

Name:

Address:

Phone:

City:

State:

Zip:

Unemployed

3. For which reason(s) were you discriminated against? (Check item(s) which specifically apply to you.)

Race/Color - (name of Race or Color)

Religion - (name of Religion)

National Origin/Ancestry - (name of National Origin or Ancestry)

Sex (  Male  Female )

Age ( Date of Birth  )

Blindness\*

Handicap (Name of handicap )

*Persons shall be considered blind only if their central vision acuity is not greater than twenty/two hundred in the better eye with corrective lenses, or if their vision is greater than twenty/two hundred (20/200) but is sometimes limited in the field of vision not greater than twenty (20) degrees.*

4. Who is the Company/Union against whom you wish to file? (The Company must be located within the City limits of Clarksville, TN. If the company headquarters are located in another state, give the local Clarksville, TN address and phone number.)

Name of Company:	<input type="text"/>
Address of Company:	<input type="text"/>
Phone:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
Zip:	<input type="text"/>
Name of Company Individual(s) causing the harm:	<input type="text"/>
Job Title:	<input type="text"/>
Date you were hired?	<input type="text"/>
Total number of company employees?	<input type="text"/>
What product or service is produced?	<input type="text"/>
Your present or former job title:	<input type="text"/>

Your present or former job duties:

Name of your Supervisor:

Title of your Supervisor:

Please select only one and indicate amount:

Rate of pay:

- Per Week  
 Bi-Weekly  
 Monthly  
 Yearly

Amount

Is there any other position to which you wish to be upgraded? If so, enter job title, duties and pay below:

Job Title:

Duties:

Rate of Pay:

5. Check the kind(s) of harm you suffered from your employer. Check only those items which apply to you:

A. Hiring:

- Unfair application
- Unfair interview
- Unfair requirements
- Unfair placement
- Unfair other

B. Promotion:

- Passed over on promotion
- Request ignored or denied
- Requirements unrealistic
- Not trained
- Other

C. Demotion:

- Status only
- In pay only
- Status and pay

6. Unfair Treatment:

- Harassment (by employees  by supervisor  )
- By employees
- By supervisor
- Unequal workload
- No written warning
- Name calling or biased stories
- Minorities unequally represented
- Other

## 7. Discipline:

<input type="checkbox"/>	Unequal
<input type="checkbox"/>	Inappropriate or excessive
<input type="checkbox"/>	No written warning
<input type="checkbox"/>	Stated procedures ignored
<input type="checkbox"/>	Given without authority
<input type="checkbox"/>	Other

## 8. What is your most recent date of discrimination? Check appropriate issue and date of the most recent incident:

<input type="checkbox"/>	Failure to hire	Date	<input type="text"/>
<input type="checkbox"/>	Discharge/Termination	Date	<input type="text"/>
<input type="checkbox"/>	Failure to reinstate after layoff, medical or other approved leave of absence	Date	<input type="text"/>
<input type="checkbox"/>	Suspension	Date (From To)	<input type="text"/>
<input type="checkbox"/>	Forced resignation	Date	<input type="text"/>
<input type="checkbox"/>	Forced maternity leave	Date	<input type="text"/>
<input type="checkbox"/>	Demotion	Date	<input type="text"/>
<input type="checkbox"/>	Reduction in wages		

Date

Retaliation

Date  Docket No. of Former Complaint

Other (please list reasons given by employer.)

9. Is the discrimination a continuing matter?

Yes

No

If yes, when did the harm begin?

10. Please explain in detail what happened to you within the last 180 days and/or include the time when the harm began:

Give name of person(s) whose race, sex, age (under age 40) etc., if different than your own who were not treated in the same manner for the same reasons:

Name:

Sex:

Male  Female

Age (under 40):

Race:

List additional names if necessary:

11. Have you discussed the problem that led to your filing this complaint with anyone in Management at your place of employment?

Yes

No

If yes, with whom did you discuss it? (name, their title, and the date):

12. Is there a union at your place of employment?

Yes

No

If yes, are you a member?

Yes

No

If yes, have you filed a grievance on this same problem?

Yes

No

If yes, what is the status of your grievance?

Step #

Arbitration

Date of Hearing

Union failure to represent  
Choose One

By Steward  By Other Officials  On Grievance

Taking to Arbitration  On Promotion  Other

13. Exact name of Union:

Local No.:

Street Address:

Phone:

City:

State:

Zip:	<input type="text"/>
Name of Union President:	<input type="text"/>
Address:	<input type="text"/>
Phone:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
Zip:	<input type="text"/>
Name of Business Agent:	<input type="text"/>
Address:	<input type="text"/>
Phone:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
Zip:	<input type="text"/>
Name of Steward:	<input type="text"/>
Address:	<input type="text"/>
Phone:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
Zip:	<input type="text"/>

14. Have you filed this same charge with any other government agency or attorney?

- Yes
- No

If Yes, answer the following:

Name of Agency/Attorney	<input type="text"/>
Address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip	<input type="text"/>
Phone	<input type="text"/>

15. Information about witnesses:

Please provide the names of any witnesses who will have first hand information about your problem. If you do not know the full name, give the part you know such as nickname, job title, work location or other bits of information you have that might help us to identify the person.

Name	<input type="text"/>
Phone	<input type="text"/>
Address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip	<input type="text"/>

What specific information does this person have of HIS/HER own knowledge that is important to your complaint. (Explain below in detail.):

Empty text area with scrollbars.

Name	<input type="text"/>
Phone	<input type="text"/>
Address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip	<input type="text"/>

What specific information does this person have of HIS/HER own knowledge that is important to your complaint. (Explain below in detail.):

Empty text area with scrollbars.

16. Do you know of any document, record or written information that will be important to your case?

- Yes
- No

If yes, list any such items below with location, if known.

1.
2.
3.
4.
5.

17. To settle your complaint, what do you want? (Examples: job back, back pay, seniority restored, guarantee of no discrimination, cleansed work record, etc.)

Please be as complete as possible in answering all of the above questions. The more information you can provide us, the better we can serve you and the many other persons who have filed complaints. Thank you!

Bottom of Form  
Please