

Appt.: _____

FOR OFFICE USE ONLY

Intake Officer: _____ Date: _____ CT: _____ ID No.: _____
Accepted or Aborted: _____ Aborted Date: _____ Reason: _____
Supervisor's Signature: _____

PRELIMINARY QUESTIONNAIRE

Please answer all questions completely, and attach additional pages if needed to complete your responses. If you do not know the answer to a question, answer by stating "not known." If a question is not applicable, write "N/A." (PLEASE PRINT)

Dates(s) of Alleged Discrimination: _____

(Note: You have 180 days to file a complaint of Employment, Public Accommodation, and Commercial Discrimination with this Agency. You have 365 days to file a complaint of Housing Discrimination with this Agency.)

Where did the alleged discrimination occur? _____ (County)

How did you hear about MCCR? _____

Have you previously filed this complaint with EEOC, HUD, or any other agency: Yes No

If yes, date filed and where: _____

1. Complainant Personal Information (Person Filing Complaint)

Last Name: _____ First Name: _____ MI: _____

Street or Mailing Address: _____ Apt or Unit #: _____

City: _____ County: _____ State: _____ Zip: _____

Phone Numbers: Home: (_____) _____ Work: (_____) _____

Cell: (_____) _____ Email Address: _____

Date of Birth: _____ Sex: Male Female Do You Have a Disability? Yes No

Please answer each of the next three questions.

- i. Are you Hispanic or Latino? Yes No
- ii. What is your Race? Please choose all that apply. American Indian or Alaskan Native Asian White
 Black or African American Native Hawaiian or Other Pacific Islander
- iii. What is your National Origin (country of origin or ancestry)? _____

Please Provide The Name Of A Person We Can Contact If We Are Unable To Reach You:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Numbers: Home: (____) _____ Other: (____) _____

2. I believe that I was discriminated against by the following organization(s): (Check those that apply)

- Employer Union Employment Agency Discriminatory Commercial Practice
 Housing Provider Place of Public Accommodation Other (Please Specify)

Organization Contact Information (If the organization is an employer, provide the address where you actually worked. If you work from home, check here__ and provide the address of the office to which you reported.)

Organization Name: _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Type of Business: _____ Job Location if different from Org. Address: _____

HR Director or Owner Name: _____

Address: _____ Phone: (____) _____

Number of Employees in the Organization at All Locations: Please Check (√) One

- Fewer Than 15 15 – 100 101 – 200 201 – 500 More than 500

Additional Organization Name: _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

HR Director or Owner Name: _____

Address: _____ Phone: (____) _____

3. Your Employment Data (Complete as many items as you are able.) **Are you a federal employee?** Yes No

Date Hired: _____ **Most Current Position:** _____

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

Job Title at Time of Alleged Discrimination: _____ Date Quit/Discharged: _____

Name and Title of Immediate Supervisor: _____

If Job Applicant, Date You Applied for Job _____ Job Title Applied For _____

4. What is the reason (basis) for your claim of employment/housing/public accommodation/commercial discrimination?

FOR EXAMPLE, if you believe that you were treated worse than someone else because of race, you should check the box next to Race. If you believe you were treated worse for several reasons, such as your sex, religion and national origin, you should check all that apply. If you complained about discrimination, participated in someone else's complaint, or filed a charge of discrimination, and a negative action was threatened or taken, you should check the box next to Retaliation. Definitions for each protected class can be found on page 7 of this questionnaire.

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Race | <input type="checkbox"/> Sex | <input type="checkbox"/> Age | <input type="checkbox"/> Retaliation |
| <input type="checkbox"/> Color | <input type="checkbox"/> National Origin | <input type="checkbox"/> Religion | <input type="checkbox"/> Harassment |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Marital Status | |
| <input type="checkbox"/> Sexual Orientation | <input type="checkbox"/> Gender Identity | <input type="checkbox"/> Familial Status (Housing Only) | |

If you checked color, religion or national origin, please specify: _____

Genetic Information (Employment Only); circle which type(s) of genetic information is involved:

- i. genetic testing ii. family medical history iii. genetic services

If you checked genetic information, how did the employer obtain the genetic information?

Other reason (basis) for discrimination (Explain): _____

5. What happened to you that you believe was discriminatory? Include the date(s) of harm, the action(s), and the name(s) and title(s) of the person(s) who you believe discriminated against you. (Example: 10/02/16 – Discharged by Mr. John Q. Public, Production Supervisor)

A. Date: _____ **Action:** _____

Name and Title of Person(s) Responsible: _____

B. Date: _____ **Action:** _____

Name and Title of Person(s) Responsible: _____

C. Date: _____ **Action:** _____

Name and Title of Person(s) Responsible: _____

D. Date: _____ **Action:** _____

Name and Title of Person(s) Responsible: _____

6. Why do you believe these actions were discriminatory? Please attach additional pages if needed.

7. What reason(s) were given to you for the acts you consider discriminatory? By whom? His or Her Job Title?

8. Describe who was in the same or similar situation as you and how they were treated. For example, who else applied for the same job you did, who else had the same attendance record, or who else had the same performance? Provide protected class characteristics (ex. race, sex, age, national origin, religion, disability, sexual orientation) of these individuals, if known, and if it relates to your claim of discrimination. For example, if your complaint alleges race discrimination, provide the race of each person; if it alleges sex discrimination, provide the sex of each person; and so on.

Of the persons in the same or similar situation as you, who was treated better than you?

Full Name Protected Class Characteristics Job Title Description of Treatment

A. _____

B. _____

Of the persons in the same or similar situation as you, who was treated worse than you?

Full Name Protected Class Characteristics Job Title Description of Treatment

A. _____

B. _____

Of the persons in the same or similar situation as you, who was treated the same as you?

Full Name Protected Class Characteristics Job Title Description of Treatment

A. _____

B. _____

Answer questions 9-12 only if you are claiming discrimination based on disability. If not, skip to question 13.

9. Please check all that apply: Yes, I have a disability
 I do not have a disability now but I did have one
 No disability but the organization treats me as if I am disabled

10. What is the disability that you believe is the reason for the adverse action taken against you? Does this disability prevent or limit you from doing anything? (e.g., lifting, sleeping, breathing, walking, caring for yourself, working, etc.).

11. Do you use medications, medical equipment or anything else to lessen or eliminate the symptoms of your disability? Yes No

If "Yes," what medication, medical equipment or other assistance do you use?

12. Did you ask your employer, place of public accommodation, or housing provider for any assistance or accommodations because of your disability? Yes No

If "Yes," when did you ask? _____ How did you ask (verbally or in writing)? _____

Who did you ask? (Provide full name and job title of person)

Describe the assistance or accommodations that you asked for: _____

How did they respond to your request? _____

13. Are there any witnesses to the alleged discriminatory incidents? If yes, please identify them below and tell us what they will say.

Full Name	Job Title	Address & Phone Number	What do you believe this person will tell us?
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A. _____

B. _____

14. Have you sought help about this situation from a union, an attorney, or any other source? Yes No
Provide name of organization, name of person you spoke with and date of contact. Results, if any?

15. What remedy are you seeking? _____

How did you come up with this remedy? _____

I SOLEMNLY AFFIRM UNDER PENALTY OF PERJURY THAT THE CONTENTS OF THE FOREGOING STATEMENT ARE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

SIGNATURE: _____ **DATE:** _____

DEFINITIONS

1. **Employer** – Maryland’s employment anti-discrimination laws only apply to those employers with 15 or more employees.
2. **Race** – classification or association based on a person’s ancestry or ethnicity.
3. **Sex** – a person’s gender.
4. **Age** – 18 years or older.
5. **Color** – skin pigmentation or complexion.
6. **National Origin** – the country or area where one’s ancestors are from.
7. **Religion** – a belief system which may or may not include spirituality. Includes all aspects of religious observances, practice, and belief.
8. **Disability** – a physical disability, infirmity, malformation, or disfigurement that is caused by bodily injury, birth defect, or illness, including epilepsy; or a mental impairment or deficiency. Disability includes any degree of paralysis, amputation, or lack of physical coordination; blindness or visual impairment; deafness or hearing impairment; muteness or speech impediment; and physical reliance on a service animal, wheelchair, or other remedial appliance or device; and mental impairment or deficiency that may have necessitated remedial or special education and related services.
9. **Reasonable Accommodation** – a request to an employer, a housing provider, or an owner/operator of a place of public accommodation to accommodate an individual with a disability that does not pose an undue hardship or expense to the person making the accommodation.
10. **Pregnancy** – the state of carrying a developing embryo or fetus within the female body.
11. **Marital Status** – married, single, in a domestic partnership, divorced, separated, and widowed
12. **Sexual Orientation** – the identification of an individual as to male or female homosexuality, heterosexuality, or bisexuality.
13. **Gender Identity** – the gender-related identity, appearance, expression, or behavior of a person, regardless of the person's assigned sex at birth, which may be demonstrated by (1) consistent and uniform assertion of the person's gender identity; or (2) any other evidence that the gender identity is sincerely held as part of the person's core identity.
14. **Familial Status** - having a child under age 18 in the household, whether living with a parent, a legal custodian, or their designee. It also covers a woman who is pregnant, and people in the process of adopting or gaining custody of child/children.
15. **Retaliation** – taking an adverse action against an individual for filing a complaint of discrimination, participating in a discrimination proceeding, or otherwise opposing discriminatory actions and behavior.
16. **Harassment** – unwelcomed conduct that is based on any of the protected classes under Maryland law. Harassment becomes unlawful where 1) enduring the offensive conduct becomes a condition of continued employment, or 2) the conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive.
17. **Genetic Information** – information about an individual’s chromosomes, genes, gene products, or inherited characteristics that may derive from an individual or a family member that is obtained for diagnostic and therapeutic purposes, and is obtained at a time when the individual to whom the information relates is asymptomatic for the disease.
 - a. **Genetic Testing** – a laboratory test of human chromosomes, genes, or gene products that is used to identify the presence or absence of inherited or congenital alterations in genetic material that are associated with disease or illness.
 - b. **Family Medical History** – a record of health information about a person and his or her close relatives. A complete record includes information from three generations of relatives, including children, brothers and sisters, parents, aunts and uncles, nieces and nephews, grandparents, and cousins.
 - c. **Genetic Services** – health services that are provided to obtain, assess, and interpret genetic information for diagnostic and therapeutic purposes and for genetic education and counseling.

Please note that these definitions are not exhaustive and are for clarification purposes only. If you need additional assistance with defining terms, please contact the Maryland Commission on Civil Rights at 410-767-8600.