

Appt.: _____

FOR OFFICE USE ONLY

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

EMPLOYMENT - 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 300 days to file a complaint of Employment 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 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 Other (Please Specify)

Employer Contact Information (Please 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.)

Employer 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 discrimination?

FOR EXAMPLE, if you feel that you were treated worse than someone else because of race, you should check the box next to Race. If you feel 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.

Race Sex Age Disability National Origin Religion Retaliation Sexual Orientation

Pregnancy Marital Status Gender Identity Color (typically a difference in skin shade within the same race)

Genetic Information; circle which type(s) of genetic information is involved: i. genetic testing ii. family medical history
iii. genetic services (genetic services means counseling, education or testing)

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

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: 01/02/18 – Discharged by Mr. John Soto, 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?

<u>Full Name</u>	<u>Protected Class Characteristics</u>	<u>Job Title</u>	<u>Description of Treatment</u>
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A. _____

B. _____

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

<u>Full Name</u>	<u>Protected Class Characteristics</u>	<u>Job Title</u>	<u>Description of Treatment</u>
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A. _____

B. _____

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

<u>Full Name</u>	<u>Protected Class Characteristics</u>	<u>Job Title</u>	<u>Description of Treatment</u>
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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 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:** _____