PORT OF OAKLAND

TITLE VI/504/ADA and Related Federal and State Statutes Discrimination Complaint Form

FOR OFFICE USE ONLY	
Date: _____	Reviewer Initials: _____

Name of Complainant:	Home Telephone Number:	Work Telephone Number:
_____	_____	_____

Mailing Address:

_____

What is the most convenient time for us to contact you about this complaint?

_____

Basis of Discriminatory Action(s):

____ RACE	____ SEX	____ MARITAL STATUS
____ COLOR	____ NATIONAL ORIGIN/ANCESTRY	____ VETERAN'S STATUS
____ RELIGION/CREED	____ PHYSICAL/MENTAL DISABILITY	____ GENETIC INFORMATION
____ AGE	____ MEDICAL CONDITION	____ RETALIATION

Date and place of alleged discriminatory actions. Please include earliest date of discrimination and most recent date of discrimination:

_____

_____

_____

How were you discriminated against? Describe the nature of the action, decision, or conditions of the alleged discrimination. Explain as clearly as possible what happened and why you believe your protected status was a factor in the discrimination. Include how other persons were treated differently from you. (Attach additional page(s), if necessary).

_____

_____

_____

Names of persons (witnesses, fellow employees, supervisors, or others) whom we may contact for additional information to support or clarify your complaint: (Attached additional page(s), if necessary).

Name	**Address**	**Telephone**
_____	_____	_____
_____	_____	_____

_____ _____

Signature of Complainant Date