CHICAGO COOK WORKFORCE PARTNERSHIP

EQUAL OPPORTUNITY/DISCRIMINATION COMPLAINT FORM

THIS FORM IS TO BE USED FOR DISCRIMINATION COMPLAINTS ONLY

Complaints filed on the basis of race, color, religion, sex (Including pregnancy, childbirth and related medical condition, sex stereotyping, transgender status, and gender identity), national origin (including Limited English Proficiency), age, disability or political affiliation or belief and an individual's citizenship status).

Complaint must be filed within 180 days from the date of alleged violation(s)

Please type or print your information. Answer each question as completely as possible. If you cannot fit your whole answer in the space provided on this form, you may add additional pages. **After completing this form in full, attach any documentation that supports your complaint.**

Please return the completed form and documentation to:
Chicago Cook Workforce Partnership
Attention: Gladys Hall, Equal Opportunity Officer
69 West Washington, Suite 2860
Chicago, Illinois 60602

1. Complainant status: ☐ Customer ☐ Applicant ☐ Participant ☐ Employee ☐ Service Provider
☐ Training Provider ☐ One-Stop Partner Other: _____

2. Please provide the following information.

Complainant Name

Street Address

City | State | Zip Code

Phone Number(s) | E-mail Address | Best time to contact you

3. Please provide the name of the agency (service provider, training provider, organization or business) that you are filing a complaint against and the name of the person(s) directly involved in your complaint.

Agency Name | Phone Number

Street Address | City, State, Zip Code

Staff Person | Job Title

Staff Person | Job Title

4. Please identify the basis of your complaint. (✓) Failure to do so may slow the processing of your complaint.

☐	Age: What is your date of birth?	
☐	Race: What is your race?	
☐	Color:	
☐	Religion:	
☐	Sex/Gender: please specify	
☐	Disability: **If applied please identify**	
	☐	I have a disability (which may be active or inactive presently)
	☐	I have a record of a disability
	☐	I do not have a disability, but the organization or agency treats me as if I am disabled.
☐	National Origin:	
☐	Political Affiliation or Belief:	
☐	Harassment: please specify	
☐	Citizenship: what is your citizenship?	
☐	Limited English Proficiency (LEP):	
☐	Related medical condition:	
☐	Retaliation: please specify	
☐	Other: (Please specify)	

5. On what date did the allegation occur? _____

6. Where did the violation occur? _____
Street Address

_____ _____ _____
City State Zip Code

7. Did anyone witness the violation? ☐ Yes ☐ No

8. If yes would he/she agree to an interview and sign a written statement to support what he/she witnessed. ☐ Yes ☐ No
If yes, please provide the name and contact information of the witness. (If necessary, attach additional pages).

_____ _____
Witness Name Phone Number

_____ _____
Street Address City, State, Zip Code

_____ _____
Witness Name Phone Number

_____ _____
Street Address City, State, Zip Code

9. Have you filed a written complaint with another agency, (e. g. DCEO's Office of Equal Opportunity Monitoring and Compliance (EOMC), Department of Labor (DOL) or Illinois Department of Human Rights (IDHR) about the same events or actions you describe on this form? ☐ Yes ☐ No.

10. If yes, please answer the following questions, as best as you can. (If necessary add additional pages). If no, please continue to question (11).

When did you file your first written complaint?

Where did you file?

Name of the Specific Office

Name of the contact person that worked on your complaint, if known

Phone Number

E-mail Address

Mailing or Street Address

City, State, Zip Code

Has the place where you filed your first written complaint given you a final decision about the complaint? ☐ Yes ☐ No

If yes, what was the date of the final decision? Was the decision in writing? ☐ Yes ☐ No. If yes, If possible include copies of the written decision with this complaint.

11. Did you choose to have a representative to present your claim? ☐ Yes ☐ No If yes, please provide the following information.

Representative Name

Organization Name/Title (If any)

Phone Number

E-mail Address

Street Address

City

State

Zip Code

12. Please provide a detailed description of your complaint, how you were harmed by what happened and how or why you believe you were discriminated against. (If necessary, attach additional pages).

13. What resolution are you seeking? (If necessary, attach additional pages).

Signature of Complainant

Date

Signature of Complainant's Representative

Date

For office use only

Signature of Equal Opportunity Officer

Date Received

Direct: 312-603-7083, E-mail address: ghall@chicookworks.org. Fax: (312) 603-9930 (9939)