



Discrimination Complaint Form

Instructions: Use this form to file a claim of discrimination based on race, color, national origin, creed/religion, age, sexual harassment, gender/ sex marital/family status, disability, arrest record, criminal conviction record, gender identity, sexual orientation, predisposing genetic characteristics, military status, domestic-violence-victim status, pregnancy and related conditions, and/or retaliation.

Complete and return this form to the Division of Military & Naval Affairs State Human Resources Office (MNHS).

Section 1: Complainant Information

Name Title
Agency/Business Unit Work Schedule (days/hours)
Work Address Work Phone
Home Address Home Phone

Section 2: Supervisory Information

Immediate Supervisor Name Title
Work Address Work Phone
2nd Level Supervisor Name Title
Work Address Work Phone

Section 3: Details of Claim

1. Your claim of discrimination is based upon (check all that apply):

- Race Disability Pregnancy and Related Conditions Predisposing Genetic Characteristics
Sexual Harassment Religion/Creed Gender/Sex Color
Age Arrest/Criminal Conviction Record Marital/Familial Status Sexual Orientation
Military Status National Origin Domestic-Violence-Victim Status Gender Identity
Retaliation

2. Your claim of discrimination is made against:

Name 1 Title
Work Address Work Phone

Relationship to you: Supervisor Co-worker Subordinate Other -> Please Specify:

Name 2 Title
Work Address Work Phone

Relationship to you: Supervisor Co-worker Subordinate Other -> Please Specify:



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3. Date(s) discrimination occurred:

Is the discrimination continuing?

Yes No

4. Please describe briefly the alleged discriminatory conduct and your reasons for concluding that the conduct was discriminatory. Please include the names of witnesses, if any, and attach supporting data, if available. Attach additional pages, if necessary.

- 5. A. Have you filed a claim regarding this complaint with a federal, state or local government agency?** Yes No
- B. Have you instituted a legal suit or court action regarding this complaint?** Yes No
- C. Have you hired an attorney with respect to the allegations in the complaint?** Yes No

6. This complaint form was completed by:
Complainant
Supervisor/Manager
Affirmative Action Administrator

Signature

Date

Return the completed form (by email, mail or fax) to the:

Agency: Division of Military & Naval Affairs
Bureau: State Human Resources
Address: 330 Old Niskayuna Road
MNHS - 4th Floor
Latham, NY 12110

Email: ng.ny.nyarnng.mbx.mnhs-benefits@mail.mil
Phone: (518) 786-4830
Fax: (518) 786-4969 or (518) 786-6051