New York State Employee Discrimination Complaint Form

Office of Employee Relations
Anti-Discrimination Investigations Division
Empire State Plaza
Agency Building 2
Albany, New York 12223
antidiscrimination@oer.ny.gov

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

Complete and return this form to the **Office of Employee Relations, Anti-Discrimination Investigations Division**.

Section 1: Complainant Information

Full Name

Preferred Email Address (for complaint related communications)

Agency/Employer
Division of Military and Naval Affairs

Title/Business Unit/Facility

Work Schedule (days/hours)

Work Location/Address

Work Phone #

Home Address

Personal Phone #

Section 2: Supervisory Information

Immediate Supervisor Name

Title

Work Location/Address

Work Phone #

2nd Level Supervisor Name

Title

Work Location/Address

Work Phone #

Section 3: Details of Claim

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

- ☐ Race
- ☐ Color
- ☐ National Origin
- ☐ Creed/Religion
- ☐ Age
- ☐ Disability
- ☐ Military Status
- ☐ Arrest/Criminal Conviction Record
- ☐ Marital/Familial Status
- ☐ Predisposing Genetic Characteristics
- ☐ Pregnancy and Related Conditions
- ☐ Domestic Violence Victim Status
- ☐ Citizenship or Immigration Status
- ☐ Gender/Sex
- ☐ Sexual Harassment
- ☐ Sexual Orientation
- ☐ Gender Identity
- ☐ Retaliation (for having engaged in a protected activity)

2. Your claim of discrimination is made against:

Name 1

Title

Agency
Division of Military and Naval Affairs

Facility/Work Location

Work Phone

Relationship to you: ☐ Supervisor ☑ Co-worker ☐ Subordinate ☐ Other → Please Specify:

Name 2

Title

Agency
Division of Military and Naval Affairs

Facility/Work Location

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 the alleged discriminatory conduct and the reasons the conduct is discriminatory. Please include the names of witnesses, if any, and attach supporting documentation, if available. Attach additional pages, if necessary.

5. Have you filed a claim regarding this complaint with a federal, state, or local government agency? ☐ Yes ☐ No

6. Have you instituted a legal suit or court action regarding this complaint? ☐ Yes ☐ No

7. Have you hired an attorney with respect to the allegations in the complaint? ☐ Yes ☐ No

8. This complaint form was completed by:

- ☐ Complainant
- ☑ Supervisor/Manager
- ☐ Anti-Discrimination Officer

Signature

Date

Return the completed form (by email or mail) to the Office of Employee Relations, Anti-Discrimination Investigations Division:

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