

DISCRIMINATION COMPLAINT FORM

SANTA CLARA COUNTY – EQUAL OPPORTUNITY DIVISION

Confidentiality: The County of Santa Clara cannot guarantee that complaints will remain confidential after an investigation has commenced because Equal Opportunity Division (EOD) records are subject to subpoena and possible discovery if a case goes to litigation, and can be subpoenaed by the Equal Employment Opportunity Commission (EEOC), a federal agency, or the California Department of Fair Employment and Housing (DFEH); however, our office will take appropriate measures to limit disclosure and maintain the confidentiality of complaints and those involved in the complaint process.

NAME of COMPLAINANT _____ Employee Applicant Client/Patient
Job Title _____ Time w/County _____ Email _____
Job Location _____ Department _____
Employee ID Number _____ Supervisor _____
Preferred method of contact (Work or Home Email, Work or Home/Cell Phone): _____
Home Address: _____
Phone: Work _____ Home _____ Cell _____

I BELIEVE I WAS DISCRIMINATED AGAINST/HARASSED BECAUSE OF MY ACUTUAL OR PERCEIVED:

Age (40 or over)	Medical Condition	Race
Ancestry	Genetic Characteristics	Retaliation*
Color	National Origin	Religious Belief
Culture	Gender Identity / Expression	Sex / Gender
Disability	Political Belief	Sexual Harassment
Pregnancy	Sexual Orientation	Organizational Affiliation
Marital Status	Military / Veteran's status	Family Care or Medical Leave

Association with any individual in any of the above groups

*If you checked Retaliation, please check what previous protected activity you engaged in:

I filed a previous Discrimination Complaint	I participated in a Discrimination Investigation
Family Care or Medical Leave	Reasonable Accommodation

ALLEGATION(S) AGAINST: _____ Job Title _____
Phone: Work _____ Cell _____
Job Location _____ Department _____
Supervisor _____ Department Director _____

As a result of the category (box) checked above, the following actions were taken against me. Please list DATE, LOCATION, DETAILS of INCIDENT: (When, Where, What, How, Frequency, Witnesses, Who did you tell, etc.) **Attach additional pages if necessary.**

REMEDY SOUGHT BY COMPLAINANT:

If eligible, would you be interested in a conflict resolution process? **Yes** **No** **Possibly, with more information.**

Signature of Complainant _____ **Date** _____

Submit Completed Form to:

Equal Opportunity Division
2310 N. 1st Street, Suite 101
San Jose, CA 95131
Phone: (408) 993-4840 Fax: (408) 993-4849
Email: EOD@eod.sccgov.org