City of Atlanta
Human Relations Commission
Complaint Form

Please be advised that this form is affected by the State of Georgia's Open Records Act, codified at O.C.G.A. 50-18-70 et seq.

PLEASE PRINT

Name: _____ Date of Birth: _____
(First) (Middle Initial) (Last)

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Telephone No. (include area code): Work _____ Home _____

Do you have an attorney representing you in this matter? If yes,

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No. (include area code): _____

PLEASE PROVIDE THE NAME OF A PERSON AT A DIFFERENT ADDRESS WHOM WE CAN CONTACT IF WE ARE UNABLE TO REACH YOU:

Name: _____ Relationship: _____ Tel. No. ( )_____

Address: _____ City: _____ State: _____ Zip _____

Why do you believe that you were discriminated against (Check all that apply)
Race _____ Color _____ Creed _____ Religion _____ Sex _____ Disability _____

Domestic Relationship Status ____ Parental Status _____ Familial Status ____

Sexual Orientation ____ National Origin _____ Gender Identity _____ Age _____

Use of a Trained Dog Guide by a Blind, Deaf or otherwise physically disabled person _____

Please read the following information before proceeding:

Your Charge of Discrimination must be filed within 180 days after the alleged unlawfulpractice has occurred.

Please complete this questionnaire and return to the Mayor's Office of Constituent Services (Suite1920 in City Hall, 55 Trinity Avenue, SW). You may be interviewed by an investigator to find out if your problem falls within the jurisdiction of the Human Relations Commission.

THE ENTITY THAT YOU BELIEVE DISCRIMINATED AGAINST YOU:

Name: _____

Address: _____ City _____ State _____ Zip _____

County: _____ Telephone No. (include area code) _____

Have you filed a Complaint with the Human Relations Commission in the past [ ] NO [ ] YES
(If *YES*, answer the following):

_____	_____	_____
Approximate date filed	Organization Charged	Charge No. (if known)

THE FOLLOWING QUESTIONS CONCERN THE SPECIFIC ACTIONS(S) TAKEN AGAINST YOU. IF YOU NEED ADDITIONAL SPACE, PLEASE ATTACH SEPARATE PAGES AND NUMBER YOUR RESPONSES.

1. What action was taken against you that you believe to be discriminatory? What harm was caused to you and/or others in your work situation because of the action?

2. What is the date this action first occurred?

3. What is the last date? _____

4. Who took this action against you (*if known*)? Name(s) and Job titles(s)

5. What reason(s) were you given for the action taken?

6. Why do you think the action was discrimination? (Provide the name, job title, and department of employee(s) in the same or similar situation treated more favorable. Explain how they were treated differently.)

7. Provide all evidence and information in your possession of discriminatory treatment. The documents that would support what you said in item four, item five or item six (Attach any documents to the form.)

8. Provide the name(s), address(es), telephone number(s), and a description of the information that can be provided by your witness(es) who you think can provide evidence in support of your allegations of discrimination:

Name	Address	Telephone	Description of Information Witness Can Provide
a.			
b.			
c.			
d.			
e.			