

Department of Administrative Services
 Equal Opportunity Division
EEO DISCRIMINATION COMPLAINT FORM

1. Name: (Last) (First) (Middle Initial)	2. Office Phone No. () -																
Home Address: (Number & Street) (City) (ZIP)	3. Home Phone No. () -																
4. Are you presently working for the State of Ohio? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which agency?																	
5. Check the appropriate area(s) of discrimination: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Race</td> <td><input type="checkbox"/> National Origin</td> <td><input type="checkbox"/> Gender Identity</td> <td><input type="checkbox"/> Veteran Status (Vietnam Era, disabled, Desert Shield/Storm)</td> </tr> <tr> <td><input type="checkbox"/> Color</td> <td><input type="checkbox"/> Ancestry</td> <td><input type="checkbox"/> Sexual Orientation</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Religion</td> <td><input type="checkbox"/> Disability</td> <td><input type="checkbox"/> Military Status</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Sex</td> <td><input type="checkbox"/> Age (40+ years)</td> <td></td> <td></td> </tr> </table>		<input type="checkbox"/> Race	<input type="checkbox"/> National Origin	<input type="checkbox"/> Gender Identity	<input type="checkbox"/> Veteran Status (Vietnam Era, disabled, Desert Shield/Storm)	<input type="checkbox"/> Color	<input type="checkbox"/> Ancestry	<input type="checkbox"/> Sexual Orientation		<input type="checkbox"/> Religion	<input type="checkbox"/> Disability	<input type="checkbox"/> Military Status		<input type="checkbox"/> Sex	<input type="checkbox"/> Age (40+ years)		
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5a. Discriminatory harassment: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Race</td> <td><input type="checkbox"/> National Origin</td> <td><input type="checkbox"/> Gender Identity</td> <td><input type="checkbox"/> Veteran Status (Vietnam Era, disabled, Desert Shield/Storm)</td> </tr> <tr> <td><input type="checkbox"/> Color</td> <td><input type="checkbox"/> Ancestry</td> <td><input type="checkbox"/> Sexual Orientation</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Religion</td> <td><input type="checkbox"/> Disability</td> <td><input type="checkbox"/> Military Status</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Sex</td> <td><input type="checkbox"/> Age (40+ years)</td> <td></td> <td></td> </tr> </table>		<input type="checkbox"/> Race	<input type="checkbox"/> National Origin	<input type="checkbox"/> Gender Identity	<input type="checkbox"/> Veteran Status (Vietnam Era, disabled, Desert Shield/Storm)	<input type="checkbox"/> Color	<input type="checkbox"/> Ancestry	<input type="checkbox"/> Sexual Orientation		<input type="checkbox"/> Religion	<input type="checkbox"/> Disability	<input type="checkbox"/> Military Status		<input type="checkbox"/> Sex	<input type="checkbox"/> Age (40+ years)		
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5b. <input type="checkbox"/> Retaliation (based on involvement with a discrimination complaint)																	
6. Race of the complainant: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander Sex of the complainant: <input type="checkbox"/> Male <input type="checkbox"/> Female																	
7. Name the agency you believe has discriminated against you: (Location)																	
8. Name(s) and title(s) of person(s) who you believe discriminated against you: (Name) (Title)																	
9. Have you filed a complaint with the federal EEO Commission? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you filed a complaint with the Ohio Civil Rights Commission? <input type="checkbox"/> Yes <input type="checkbox"/> No																
9. Have you filed a Union grievance regarding the incident(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
10. Date of the alleged discrimination:	11. State agency where you were employed at the time: (Your Classification)																
12. Explain how you believe you were discriminated against (treated differently from other employees or applicants) BECAUSE of your race, color, religion, sex, national origin, ancestry, disability, age (40 years or more), sexual orientation, gender identity, military status or veteran status (Vietnam Era, disabled or Desert Shield/Storm). Attach additional sheets if needed.																	
13. Date complaint filed:	14. Complainant's signature:																

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TERMS AND CONDITIONS				
<input type="checkbox"/> Discipline	<input type="checkbox"/> Suspension	<input type="checkbox"/> Promotion	<input type="checkbox"/> Transfer	<input type="checkbox"/> Disparate Treatment
<input type="checkbox"/> Training	<input type="checkbox"/> Failure to Hire	<input type="checkbox"/> Demotion	<input type="checkbox"/> Removal	<input type="checkbox"/> Probationary Removal
ADM 4400 (Rev. 12/2008)				