Florida Commission on Human Relations

Technical Assistance Questionnaire for Employment Complaints

Your answers to this questionnaire are confidential pursuant to Florida Statute 760.11(12).

The primary purpose of this questionnaire is to solicit information about claims of employment discrimination, determine whether the Florida Commission on Human Relations (FCHR) has jurisdiction over those claims and provide charge filing counseling, as appropriate. Providing this information is voluntary, but the failure to do so may impede the Commission's investigation of a charge. It is not mandatory that this form be used to provide the requested information. NOTE: The FCHR may disclose the information included on this form to other state, local and federal agencies, as appropriate or necessary to carry out the Commission's functions, or if the FCHR becomes aware of a civil or criminal law violation. If the FCHR accepts this form as a charge, this form will be provided to the employer, union or employment agency identified.

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Please complete this entire form (please print) and return it to the Commission at the address listed at the bottom of this form. Answer all questions completely. Attach additional pages, if needed, to complete your responses. If you do not know the answer to a question, answer by stating "not known." If a question is not applicable, write "N/A."

REMEMBER, a charge of employment discrimination must be filed within 365 days of the alleged act of discrimination.

1. **Personal Information**

Last Name: _____ First Name: _____ MI: _____

Street or Mailing Address: _____ Apt or Unit #: _____

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

Phone Numbers: Home: (_____) _____ Work: (_____) _____

Mobile telephone: (_____) _____ Email address: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

2. Please provide the name of a person we can contact if we are unable to reach you:

Name: Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Other Phone: (____) _____

3. I believe that I was discriminated against by the following organization(s): (Check those that apply)

☐ Employer ☐ Union ☐ Employment Agency ☐ Other (please specify) _____

Organization Contact Information (If the organization is an employer, provide the address where you actually worked. If you work from home, check here ☐ and provide the address of the office to which you reported.) If more than one employer is involved, attach additional sheets.

Organization Name: _____

Address: _____ County: _____

City: _____ State: ____ Zip: _____ Phone: (____) _____

Type of Business: _____ Job Location if different from Organization's Address: _____

_____

Human Resources Director/ Owner Name: _____ Phone: (____) _____

4. Organization Representative Contact Information (If known):

Representative Name: _____

Address: _____ County: _____

City: _____ State: ____ Zip: _____ Phone: (____) _____

Phone Numbers: Home: (_____) _____ Work: (_____) _____

Mobile telephone: (_____) _____ Email address: _____

5. Does the organization employ <u>15 or more employees</u> (include all locations/branches/offices)?

- **☐ Yes**
- **☐ No**
- **☐ Not sure**

6. Your Employment Data (complete as many items as you are able.)

Date Hired: _____ Job Title At Hire: _____

Job Title at Time of Alleged Discrimination: _____ Date Quit/Discharged: _____

Name and Title of Immediate Supervisor: _____

If Job Applicant, Date Applied for Job: _____ Job Title Applied For: _____

7. What is the reason (basis) for your claim of employment discrimination?

FOR EXAMPLE, if you feel that you were treated worse than someone else because of race, you should check the box next to Race. If you feel you were treated worse for several reasons, such as your sex, religion and national origin, check all that apply. If you complained about discrimination, participated in someone else's complaint or filed a charge of discrimination and a negative action was threatened or taken, you should check the box next to Retaliation.

☐ Race: ☐ Black ☐White ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian or Alaska Native

☐ Color: ☐ Light Skinned ☐ Dark Skinned ☐ Other: _____

☐ National Origin: ☐ Hispanic ☐ Mexican ☐ Arab/Afghani/Middle Eastern ☐ East Indian ☐ Other: _____

☐ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

☐ Sex: ☐ Female ☐Male

☐ Pregnant or condition related to pregnancy or childbirth

☐ Age: ☐ Under 40 years old ☐ 40 years or older

☐ Retaliation

☐ Religion (Please identify): _____

☐ Disability/Handicap: ☐ Physical ☐ Mental

☐ Genetic Information - Circle which type(s) of genetic information is involved:

1. **Genetic testing ☐**
2. **Family medical history ☐**
3. **Genetic services (counseling, education or testing) ☐**

☐ Other Reason (basis) for Discrimination (describe): _____

8. What happened to you that you believe was discriminatory? Include the date(s) of harm, the action(s), and the name(s) and title(s) of the person(s) who you believe discriminated against you. **Please attach additional pages if needed.** *(Example: 08/08/2011 – Discharged by Mr. John Smith, Supervisor)*

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Answer question 9 only if you are claiming discrimination based on disability. If not, skip to question 10.

9. Do you have a disability, which is a physical or mental impairment that substantially limits a major life activity, such as caring for yourself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working? Please check all that apply:

☐ **Yes, I have a disability.**

☐ **I do not have a disability now but I did have one.**

☐ **No disability, but the organization treats me as if I am disabled.**

☐ **No disability, but the organization is aware that I am caring for a disabled individual.**

10. Have you filed a charge previously on this matter with the EEOC or another agency? ☐ Yes ☐ No
If so, provide the name of the agency and the date of filing: _____

_____

11. Have you sought help about this situation from a union, an attorney or any other source? ☐ Yes ☐ No

If so, provide the name of organization, name of person you spoke with, date of contact and the results or outcome, if any.

_____

_____

Please check one of the boxes below to tell us what you would like us to do with the information you are providing on this questionnaire. If you would like to file a charge of job discrimination, you must do so within 365 days from the date you were allegedly discriminated against. **If you do not file a charge of discrimination within the time limit, you will lose your ability to file a charge. If you would like more information before filing a charge or you have concerns about the FCHR notifying the employer, union or employment agency about your charge, check Box 1. If you want to file a charge immediately, check Box 2.**

BOX 1 ☐ I want to talk to an FCHR employee before deciding whether to file a charge. I understand that by checking this box, I have not filed a charge with the FCHR. **I also understand that I could lose my ability to file a charge if I do not file in time.**

BOX 2 ☐ I want to file a charge of discrimination, and I authorize the FCHR to look into the actions described above. I understand that **the FCHR must give the employer, union, or employment agency that I accuse of discrimination information about the charge, including my name.** I also understand that the FCHR can only accept charges of job discrimination based on race, religion, sex, pregnancy, national origin, disability, age, genetic information, or retaliation for opposing discrimination. **By signing below, I verify that I have read the above information and that the facts stated are true.** *If you have checked **Box 2**, and your case is already 350 days or more from the alleged discrimination, the FCHR will accept this form as a charge if it meets the elements of a charge, consistent with Rules 60Y-5.001(5) and (6), F.A.C.*

Signature: _____ Date: _____

Mail or Fax to: **Florida Commission on Human Relations**
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Tallahassee, Florida 32399-7020
Telephone (850) 488-7082
Facsimile (850) 487-1007