

Employment Development Department Discrimination Complaint Form

Please use this form to file a discrimination complaint to the Employment Development Department (EDD). To submit a discrimination complaint, complete this form and send it to the Equal Opportunity (EO) Officer.

By mail: Employment Development Department
Equal Opportunity Officer
PO Box 826880, MIC 83
Sacramento, CA 94280-0001

By fax: 916-654-9371
Attn. to: Equal Opportunity Officer

1. Complainant Information:	
<input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Mr. <input type="checkbox"/> Other	Home Phone: _____ Work Phone: _____ Cell: _____
Name: _____	
Street Address: _____	
City: _____	E-mail: _____
State: _____	Zip Code: _____

2. Complainant Contact Information:					
When is a convenient time during business hours (8 a.m. to 5 p.m.) to contact you by phone about this complaint?					
Day	Monday	Tuesday	Wednesday	Thursday	Friday
Time					
Phone Number					

3. Contact Information for the person(s) who you claim discriminated against you:		
Provide the name of the entity where person(s) work(s):		
Name of person(s) who discriminated against you:		
Address of person(s)/entity:		
City: _____	State: _____	ZIP Code: _____
Phone: _____		
Date of first occurrence: _____		Date of most recent occurrence: _____

4. Tell us about the incident(s):

- Explain briefly what happened and how you were discriminated against.
- Provide the date(s) when the incidents(s) occurred.
- Indicate who discriminated against you. Include names and titles, if possible.
- If other people were treated differently than you, tell us how they were treated differently.
- Attach any documents that you think may help us better understand your complaint.

5. Please list below any person(s) (witnesses) that we may contact for additional information to support or clarify the complaint.

Name	Address	Phone

6. Basis for the discrimination:

- Check the type of discrimination you experienced, such as age, race, color, national origin, disability, etc.
- If you believe more than one basis was involved, you may check more than one box:

- | | |
|---|---|
| <input type="checkbox"/> Age – <i>Date of birth:</i> | <input type="checkbox"/> Citizenship or status as alien U.S. worker |
| <input type="checkbox"/> Color | <input type="checkbox"/> Disability |
| <input type="checkbox"/> National origin (including limited English proficiency) | <input type="checkbox"/> Political affiliation or belief |
| <input type="checkbox"/> Retaliation | <input type="checkbox"/> Religion |
| <input type="checkbox"/> Race – <i>Indicate race:</i> | <input type="checkbox"/> Sexual harassment |
| <input type="checkbox"/> Sex (including pregnancy, childbirth, and related medical conditions, sex stereotyping, transgender status, and gender identity) | <input type="checkbox"/> Sexual orientation |
| | <input type="checkbox"/> Other (<i>Specify</i>): |

7. Have you previously filed a complaint against this person(s)/entity?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES , answer the questions below, if NO , go to section 8.			
a. Was your complaint in writing?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. On what date did you file the complaint?			
c. Name of office where you filed your complaint:			
Address:			
City:		State:	ZIP Code:
Phone number:		Contact person (if known):	
d. Have you been provided a final decision or report?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you marked "YES", please attach a copy of the complaint.			

8. What corrective action or remedy do you seek? Please explain:

9. Choosing a personal representative:		
<ul style="list-style-type: none"> ▪ You may choose to have someone else represent you in dealing with this complaint. It may be a relative, friend, union representative, an attorney, or someone else. ▪ If you choose to appoint someone to represent you, all of our communication to you will be routed through your representative. 		
Do you want to authorize a personal representative to handle this complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If YES , complete the section below. If NO , go to Section 10.		
AUTHORIZATION OF PERSONAL REPRESENTATIVE		
I wish to authorize the individual identified below to act on my behalf as my personal representative in matters such as mediation, settlement conferences, or investigations regarding this complaint.		
Name:		
<input type="checkbox"/> I am an attorney representing the complainant. <input type="checkbox"/> I am not an attorney representing the complainant.		
Mailing Address:		
City:	State:	ZIP Code:
Phone:	Fax:	
E-mail:		

10. Alternate Dispute Resolution (ADR) also known as mediation.

Notice: You must indicate if you wish to mediate your case. The EO Office cannot begin to process your complaint until you have made a selection. Please check **YES** or **NO** in the spaces below.

- Mediation is an alternative to having your complaint investigated.
- Neither party loses anything by mediating.
- The parties to the complaint review the facts, discuss opinions about the facts, and strive for an agreement that is satisfactory for both.
 - Agreement to mediate is not an omission of guilt by the person(s)/entity that you claim discriminated against you.
 - Mediation is conducted by a trained, qualified, and impartial mediator.
 - Your (or your Personal Representative) have control to negotiate a satisfactory agreement.
 - **Terms of the agreement are signed by the complainant and the person(s)/entity that claim discriminated against you.**
 - **Agreement are legally binding on both parties.**
 - If an agreement is not reached, a formal investigation will start.
 - Failure to keep an agreement will result in a formal investigation.
 - A formal investigation will be opened if retaliation is reported.
- **Do you wish to mediate your complaint?**
(Please check only one box)

YES, I want to mediate. **NO**, please investigate.

11. Complainant's Signature:

Your signature on this form will initiate the processing of this complaint. By signing this form, you are declaring under penalty of perjury that the information included is true and correct to the best of your knowledge or belief.

Signature: _____ **Date:** _____

EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids and/or alternate formats need to be made by calling 916-654-8434 (voice). TTY users, please call the California Relay Service at 711.