



EMPLOYMENT DISCRIMINATION CHARGE QUESTIONNAIRE

BROWARD COUNTY CIVIL RIGHTS DIVISION

115 S. ANDREWS AVENUE, SUITE A-600 FORT LAUDERDALE, FLORIDA 33301 TELEPHONE: (954) 357-7800 FAX: (954) 357-7817 TTY: (954) 357-6181 WWW.BROWARD.ORG/CIVILRIGHTS

IMPORTANT NOTICE TO POTENTIAL CHARGING PARTY: Completion of this form is necessary in order for the Civil Rights Division (Division) to determine if you have sufficient legal grounds to initiate the filing of a charge of employment discrimination.

Completion and submission of this questionnaire does not constitute the filing of a charge of discrimination. Upon receipt of this completed questionnaire, we will determine if you have stated sufficient factual allegations to proceed further. If the facts are not sufficient, we will either contact you for further information or notify you of our determination that the facts are not sufficient. If the facts are sufficient, a complaint will be prepared for you to sign, notarize and return to the Division for filing and investigation. You must return the signed and notarized charge document so that it is received by the Division within 365 days of the date of the most recent act of alleged discrimination.

When completing this form, please print legibly or use a typewriter. Please do not write on the reverse side of the page. Use additional sheets if necessary.

1. PERSONAL INFORMATION:

Last Name: First Name: MI: Street/Mailing Address: Apt./Unit #: City: County: State: Zip: Phone Numbers: Home: Work: Cell: Email Address: Date of Birth: Sex: Male Female National Origin/Ethnicity: Do you have a disability? Yes No How did you hear of our office?

PROVIDE THE NAME OF A PERSON WE CAN CONTACT IF WE ARE UNABLE TO REACH YOU:

Name: Relationship: Address: City: State: Zip: Home: Other:

2. INFORMATION ABOUT YOUR DISCRIMINATION CLAIM:

I believe that I was discriminated against by the following employer/organization:

Employer's/Organization's Name: Employer's/Organization's Address: County: City: State: Zip: Type of Business: Telephone:

7. WHAT REASON(S) WAS GIVEN TO YOU FOR THE ACTS YOU CONSIDER DISCRIMINATORY? BY WHOM? TITLE?

8. DURING MY EMPLOYMENT, I DID DID NOT RECEIVE ANY DISCIPLINARY ACTIONS. IF DISCIPLINARY ACTIONS WERE RECEIVED, PLEASE PROVIDE THE TYPE OF DISCIPLINARY ACTION AND THE DATE.

9. NAME AND DESCRIBE OTHERS WHO WERE IN THE SAME SITUATION AS YOU. EXPLAIN ANY SIMILAR OR DIFFERENT TREATMENT. WHO WAS TREATED WORSE, WHO WAS TREATED BETTER AND WHO WAS TREATED THE SAME? IDENTIFY EACH INDIVIDUAL BY NAME, RACE, SEX, AGE, NATIONAL ORIGIN, ETC. AS APPROPRIATE.

10. ARE THERE ANY WITNESSES TO THE ALLEGED DISCRIMINATORY INCIDENT(S)? Yes No If yes, please provide the names, addresses and contact numbers for all persons who have knowledge about the alleged discriminatory treatment and indicate what each person knows about this matter.

11. WHAT RELIEF ARE YOU SEEKING IN THIS MATTER OR WHAT WOULD YOU BE WILLING TO ACCEPT TO RESOLVE THIS MATTER IMMEDIATELY?

12. ARE YOU WILLING TO PARTICIPATE IN MEDIATION TO SEEK AN EARLY RESOLUTION OF YOUR CLAIM(S)?

Yes No

13. HAVE YOU SOUGHT ASSISTANCE FROM ANY OTHER AGENCY, ATTORNEY, ETC? Yes No If yes, please provide the name of the person or organization you spoke with, the date of assistance and the results, if any.

14. HAVE YOU PREVIOUSLY FILED A COMPLAINT WITH THE DIVISION OR EEOC? Yes No If yes, when did you file?

(Month) (Day) (Year)

INFORMATION ABOUT YOUR DISABILITY

IF YOU ARE CLAIMING DISCRIMINATION BASED ON DISABILITY, PLEASE ANSWER THE FOLLOWING QUESTIONS:

15. DO YOU (OR THE PERSON YOU ARE ASSISTING) HAVE A PHYSICAL OR MENTAL IMPAIRMENT? Yes No

16. WHAT IS THE NAME OF YOUR DISABILITY? HOW DOES YOUR DISABILITY AFFECT OR LIMIT YOUR DAILY LIFE OR WORK ACTIVITIES? (Example: lifting, sleeping normally, breathing normally, pulling, walking, climbing, caring for oneself, working, seeing, hearing, speaking, performing manual tasks, other, etc.)

17. IS YOUR DISABILITY PERMANENT? Yes No If you answered no, how long is your disability expected to persist?

18. DID YOU ASK YOUR EMPLOYER FOR AN ACCOMMODATION IN WORKING CONDITIONS BECAUSE OF YOUR DISABILITY? Yes No
If you answered yes, when did you make the request? Was it written or verbal? To whom did you make the request? What was the employer's response to your request for an accommodation?

- A. I have been advised by a representative of the Broward County Civil Rights Division (Division) that completion of this questionnaire is necessary in order for the Division to determine if I have sufficient legal grounds to initiate the filing of a charge of employment discrimination. I understand that completion and submission of this questionnaire does not constitute the filing of a charge of employment discrimination and that upon receipt and review of this completed questionnaire, the Division will determine if I have stated sufficient factual allegations to proceed with the actual filing of a charge of employment discrimination.
- B. I understand that to be timely filed, a charge of discrimination must be signed, notarized, and received by the Division within 365 days of the date of the most recent act of alleged discrimination.
- C. I have been given assurances by an agent of the Division that pursuant to Broward County's Human Rights Ordinance (Chapter 16 ½), and applicable Florida Statutes, this Questionnaire will be considered confidential and will not be disclosed (except to the parties to this proceeding, including the employer and its legal representative) as long as the case remains open, unless it becomes necessary for the Division to produce the Questionnaire in a formal proceeding. Upon the closing of this case, the Questionnaire may be subject to further disclosure in accordance with Chapter 16 ½ and Florida's Public Record Act.

Under penalty of perjury, I declare that I have read the entire contents of this questionnaire and that my answers and statements contained herein are true and correct.

Signed: _____

Printed Name: _____

Date Signed: _____