



# STATE OF ALASKA

## Equal Employment Opportunity Program

### Employment Discrimination Complaint Form

Your completed form may be mailed or returned in person to the Division of Personnel  
550 West 7<sup>th</sup> Avenue, Suite 1960, Anchorage, Alaska 99501. You may also fax your form  
to (907) 375-7719. If you have any questions, please call (907) 375-7700.

#### A) Basic Information:

Today's Date	I am a current State of Alaska employee. <input type="checkbox"/> I am a former State of Alaska employee. <input type="checkbox"/> I am an applicant for state employment. <input type="checkbox"/>	Name of Supervisor or Hiring Manager (If Applicable)	
Last Name	First Name	MI	Job Title
Department	Division	Section	
Home Address	Please use this address. <input type="checkbox"/>	Work Address	Please use this address. <input type="checkbox"/>
Home/Cell Phone	Work Phone	Email	
Work Location (City)	Position Applied For (If Applicant for State Employment)	Application Date	

#### B) I believe that I was discriminated against due to my (check all that apply):

<input type="checkbox"/> Disability	<input type="checkbox"/> Parenthood	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Religion: _____	<input type="checkbox"/> National Origin: _____	<input type="checkbox"/> Sex: _____
<input type="checkbox"/> Marital Status/Change in Status	<input type="checkbox"/> Retaliation *	<input type="checkbox"/> Genetic Information
<input type="checkbox"/> Color: _____	<input type="checkbox"/> Race: _____	<input type="checkbox"/> Age: _____

\*Being demoted, dismissed, harassed, or otherwise "retaliated" against because you complained about discrimination or participated in an EEO investigation.

#### C) What happened?

Initial Date of Alleged Discrimination	Most Recent Date of Alleged Discrimination	The situation is continuing. <input type="checkbox"/>
Name of a Witness or Someone Treated More Favorably (If Applicable)		Contact Number
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Please describe the action(s) that occurred that you believe was discriminatory and indicate what harm(s), if any, occurred as a result of the action(s). Please attach additional pages if necessary.

**D) Other Information:**

Have you filed this complaint verbally or in writing with any other individuals or agencies? This includes external entities, departmental human resources, and your chain of command. If you have filed this complaint in other forums, please indicate with whom it was filed and how it was handled. Include dates if known. Please attach additional pages if necessary.

This is my first complaint regarding this situation. ☐

How would you like to see this matter resolved? Please attach additional pages if necessary.

I affirm that the above information is true to the best of my knowledge. I understand that an impartial investigation will be undertaken in response to this complaint. I understand that filing a false or frivolous report may be considered grounds for disciplinary action that may result in suspension or dismissal. I understand that I will be informed of the outcome of the investigation, although I may not be told some confidential details. Should my contact information change, I will notify the EEO Program office with my current phone number and address.

SIGNATURE OF PERSON REPORTING

DATE