

**STATE OF WEST VIRGINIA
HUMAN RIGHTS COMMISSION**
Room 108A, 1321 Plaza East, Charleston, WV 25301-1400
Ph: (304) 558-2616 Fax: (304) 558-0085 Toll Free: (888) 676-5546 www.hrc.wv.gov

*** (INTERNET FORM) ***

EMPLOYMENT
PRE-COMPLAINT BACKGROUND FORM

Please do your best to provide complete answers to **each** of the following questions. If a question does not apply to your situation, mark that question as n/a or not applicable.

NOTICE: THIS IS NOT A CONFIDENTIAL DOCUMENT. A copy of this questionnaire, containing your answers and any statements and attachments you provide, may be released to anyone who submits a proper request, including the responding employer. **Do not attach documents, such as medical records, to this form.**

Today's Date: _____

Your Complete Contact Information

It is important that the Commission be able to reach you. If your contact information changes, please let the Commission know immediately.

Mr. ___ Miss ___ Mrs. ___ Ms. ___ Full Name _____
Street Address _____ City _____
County _____ State _____ Zip _____ E-mail _____
Ph (home) _____ (work) _____ (cellular) _____
Date of Birth _____ Age _____ Sex _____ Race _____ National Origin _____
The best time to call me is: **Mornings** ___ **Afternoons** _____. The best number to call is _____.

Your Legal Representation

You do not need an attorney to file a complaint. However, if you are represented by a lawyer, please provide the attorney's contact information and ask your lawyer to submit a written notice of representation.

Lawyer Name _____
Law Firm _____
Address _____
City _____ State _____
Zip _____ Ph _____

Your Emergency Contact Information

Please provide contact information for a family member or friend, **who does not share your address or telephone number(s)**, and who can reach you or get a message to you if the Commission is unable to contact you.

Name _____
Relationship to you _____
Street Address _____
City _____ State _____ Zip _____
Ph (h) _____ (cell) _____

Other Complaints You Have Filed

Have you filed **this same complaint or charge** with:
EEOC? Yes ___ No ___
In state or federal court? Yes ___ No ___
Have you ever filed **any complaint** here before?
Yes ___ No ___
Approximate date(s) you filed _____
Docket Number(s) _____
Who did you file against? _____

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IMPORTANT NOTICE: Completing and returning this form **DOES NOT** mean you have filed a complaint. Additional steps must be taken to file a formal complaint with the HRC. It is vital that you submit this form well before the 365 day deadline to ensure that your complaint is completed on time. **If you are submitting this form within one month of your 365 day filing deadline, please call the West Virginia Human Rights Commission for further instructions.**

Who Is Your Complaint Against?

The entity you charge with discrimination is called the **Respondent**.

My complaint is against:

_____ An Employer _____ An Employment Agency _____ A Labor Organization _____ Other

Please provide the following information for the entity against whom you want to file your complaint. If the company's headquarters is located in another state, provide the local West Virginia address and phone number. Please do your best to provide the full legal name of the company or entity you are charging with discrimination. (One place where you might find the full legal name is on a pay stub.)

Full Company Name _____

Address _____

City _____ State _____ Zip _____

County _____ Ph _____ Fax _____

If you are complaining about an employer

Is the employer:

_____ state/local government or _____ a company or sole proprietorship

If you are complaining about a company or sole proprietorship, does the employer have **12** or more employees? Yes _____ No _____ Unknown _____

Please list the number or approximate number of persons employed by this employer: in West Virginia? _____ in the U.S.? _____

If you work/have worked for this employer, please provide your start date, job title at the time discrimination occurred and end date of employment (if you are no longer there).

Start Date _____ End Date _____

Job Title/Description _____

If you are complaining about a labor organization

Were/are you a member of the labor organization?

Yes _____ No _____

Date you first joined? _____

Are you currently a member? Yes _____ No _____

Date membership expired/ended _____

What is the Local designation number? _____

If you have/had a Union Representative, please provide his/her name and contact information:

Name _____

Address _____

City _____ State _____

Zip _____ Ph _____

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What Happened?

Please **check** each type of harm that applies to your situation and provide the **date(s)** upon which the alleged unfair treatment occurred.

<input checked="" type="checkbox"/>	<u>Type of Harm</u>	<u>Date(s) of Harm</u>
<input type="checkbox"/>	Failure to Hire/Promote	
<input type="checkbox"/>	Failure to Reinstatement/Rehire/Recall	
<input type="checkbox"/>	Failure to Accommodate	
<input type="checkbox"/>	Unequal Discipline/Suspension	
<input type="checkbox"/>	Demotion	
<input type="checkbox"/>	Unequal Pay or Benefit	
<input type="checkbox"/>	Cut in Pay or Hours	
<input type="checkbox"/>	Sexual Harassment	
<input type="checkbox"/>	Hostile Work Environment (only if motivated by Sex, Race, Color, Age, National Origin, Ancestry, Religion and/or Disability)	
<input type="checkbox"/>	Forced Maternity Leave	
<input type="checkbox"/>	Forced Resignation	
<input type="checkbox"/>	Discharge/Termination/Lay-off	
<input type="checkbox"/>	Other	

If you claim you were racially or sexually harassed, were you harassed by

- a co-worker
- a manager
- a boss
- other (describe _____)

For each person whom you claim harassed you, please provide his or her name, job title and address, if known.

Name _____
 Job Title _____
 Address _____
 City _____ State _____
 Zip _____ Ph _____

Alleged Unlawful Bias

What do you believe motivated your unfair treatment? Check **ALL** the factors that you believe **actually apply** to your situation.

- | | |
|--|---|
| <input type="checkbox"/> Race | <input type="checkbox"/> Ancestry |
| <input type="checkbox"/> Color | <input type="checkbox"/> National Origin |
| <input type="checkbox"/> Sex | <input type="checkbox"/> Religion |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Disability/Blindness |
| <input type="checkbox"/> Age (40 or older) | <input type="checkbox"/> Retaliation for opposing unlawful discrimination |

If you believe your unfair treatment was motivated by **disability** discrimination, please provide the following information: **Check all that apply:**

- I have a disability.
- I had a disability in the past.
- I do not have a disability, but the employer treats/treated me as if I do have a disability or regards me as disabled.

My disability is: _____

If you believe your unfair treatment was motivated by your **color**, please describe your color.

If you believe your unfair treatment was motivated by your **ancestry**, please identify your ancestry.

If you believe your unfair treatment was motivated by your **religion**, please identify your religious affiliation, if any. _____

If you believe your unfair treatment was motivated by **retaliation** for your efforts to oppose unlawful discrimination, please provide the following information.

Was your unfair treatment motivated by:

- a. having previously assisted the Commission in an investigation? Yes ___ No ___
- b. having complained to your employer about unlawful discrimination? Yes ___ No ___
- c. having filed a previous complaint with the Commission? Yes ___ No ___

