



# DISCRIMINATION COMPLAINT FORM

Equal Employment Opportunity Policy #: 1-6

(Submit to Human Resources, [HR@billingsmt.gov](mailto:HR@billingsmt.gov) )

## Complainant Information

Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Department: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Basis of Complaint (Check appropriate box(es)):

<input type="checkbox"/> Race	<input type="checkbox"/> Sex	<input type="checkbox"/> Creed
<input type="checkbox"/> Color	<input type="checkbox"/> Age	<input type="checkbox"/> Religion
<input type="checkbox"/> National Origin	<input type="checkbox"/> Disability	<input type="checkbox"/> Marital Status

Detailed Statement of the Complaint: Provide a description of the incident(s), including the date(s), location(s) and the presence of any witnesses. Describe in your own words the actions of all those involved – attach additional pages if necessary.

If known, names of other individuals who may have witnessed or been subject to the same or similar behavior:

Any other information potentially relevant to the complaint/investigation:

I understand that Human Resources will conduct an investigation of my report. A report of discrimination, its investigation, the outcome of the investigation and any action taken relating to a specific employee is confidential. Dissemination of confidential information shall be limited to persons with a need-to-know in order to conduct an investigation and take appropriate corrective actions.

I understand that false accusations are not tolerated and will be addressed with the appropriate corrective actions.

I hereby authorize the dissemination of information regarding this report to other people with a need to know. I acknowledge that I have read and understand the above statements and certify that all information I have provided is true to the best of my knowledge.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Complainant)