INTAKE QUESTIONNAIRE
FLORIDA COMMISSION ON HUMAN RELATIONS

FCHR USE
Intake Counselor:

(Please Type of Print)

Today's Date: _____

NAME:

_____
(First) (Middle Name or Initial) (Last)

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

COUNTY YOU LIVE IN: _____ COUNTY YOU WORKED) IN: _____

HOME TELEPHONE NO.: (____) _____ WORK PHONE NO.: _____

PLEASE PROVIDE THE NAME OF AN INDIVIDUAL AT A DIFFERENT ADDRESS WHO IS IN THE LOCAL AREA AND WHO WOULD KNOW HOW TO REACH YOU:

NAME: _____ *PHONE NO.* _____

Have you sought assistance, or filed a complaint, about the action you believe to have been discriminatory? If so, with which agency of government, your union, an attorney, or from any other source? If yes, please complete below.

Name of Source of Assistance: _____

When did you seek assistance (date): _____ Results, if any: _____

_____

Have you previously filed a complaint/charge of discrimination with FCHR, EEOC, or any other agency?

☐ No ☐ Yes (If yes, please complete below)

Approximate date filed: _____ Who was the Respondent/Employer: _____

Complaint/Charge Number, if known: _____

Do you believe that you were discriminated against based upon one of the following? Check only the basis that applies to you.

Race [ ] Color [ ] Religion [ ] National Origin [ ] Age [ ]

Sex [ ] Retaliation [ ] Familial Status [ ] Marital Status [ ] Disability/Handicap [ ]

Please indicate the following as relevant to your particular complaint:

Your sex (if complaint is based on sex): Male [ ] Female [ ]

Your race (if complaint is based on race): Black [ ] White [ ] Hispanic [ ]

American Indian [ ] Asian/Pacific Islander [ ] Alaskan National [ ]

Your national origin (if complaint is based on national origin): _____

Your religion (if complaint is based on religion): _____

Your handicap/disability (if complaint is based on disability): _____

Your marital status (if complaint is based on marital status): Married [ ] Single [ ] Widowed [ ] Divorced [ ]

What was the most **recent** date that you were allegedly discriminated against? _____

The Employer, Company, Union, Employment Agency, Government Agency, or other Respondent. Please provide the name, address and telephone number of the Employer which you are alleging discriminated against you. If you are filing a housing or public accommodation complaint, please provide the name of the apartment complex, condominium association or development, or so forth, as appropriate:

Name: _____
(Company, business, corporation, union, employment agency, government agency, etc.)

Personnel Officer or other contact person:_____

Address: _____

_____
(City, State, Zip Code)

Phone Number: _____

Please indicate the approximate number of persons employed by the Employer which you are alleging discriminated against you. If this is a housing case, please give the approximate number of units, houses, etc., in the development, etc.

_____

Are you now employed by the Employer that you believe discriminated against you?

YES: Since: _____ Current Position: _____
Date of Initial Employment

If NO, please complete:

I applied for the position of :_____ on _____
(Job Title) (Date you applied)

I was employed as: _____ until _____ when I was laid off [ ] fired [ ] other [ ]
(Job Title) (Date)

What action was taken against you that you believe to be discriminatory? What harm, if any, was caused you or others in the work situation as a result of that action? For example, were you discharged, denied a promotion, not hired, etc. (If housing: were you refused opportunity to rent or buy, evicted, etc.? If public accommodation, were you denied service, etc.?

_____

_____

_____What

reasons, if any, were given you for the action taken against you?

_____

_____

_____Why do you

believe that your race, color, sex, religion, national origin, age, handicap (disability), marital status, familial status, retaliation,

determined the action that was taken against you?

_____

_____

_____

_____

Do you have any direct evidence which would support your claim that the action taken against you was because of your race, color, sex, religion, national origin, age, handicap (disability), marital status, familial status, or in retaliation for having engaged in protected activity? (An example of direct activity would be a company memo in which it is stated that the company wants to get rid of older workers).

[ ] I do have direct evidence, as described below:

[ ] I do not have direct evidence.

Do you know of anyone who was treated differently from you, under similar circumstances? If so, please identify such person or persons by name and job title (if employment case). Also, please identify the person's classification as related to the basis, or reason, for filing the complaint. (For example: If you are filing a race complaint, identify the race of the comparative person.) Please briefly explain what act(s) comparative person committed, and how that person was treated differently than you.

Please provide the names, addresses, and telephone numbers (if known), of any relevant witnesses:

I swear or affirm, under penalty of perjury, that my answers to the foregoing questions are true and correct.

Complainant's Signature Date

For FCHR Intake Use Only:

Intake Notes:

FLORIDA COMMISSION ON HUMAN RELATIONS
325 John Knox Road, Suite 240, Building F
Tallahassee, Florida 32303-4149

CHARGE OF DISCRIMINATION		FCHR No.	
Name (Indicate Mr., Ms., or Mrs.)		Social SecurityNumber	Date of Birth
Street Address		Home Telephone Number (area code)	
City, State, and Zip Code		Work (if possible to call you there)	

List the employer, labor organization, employment agency, apprenticeship committee, government agency, or other person who discriminated against you.

Name	No. of Employees	Telephone No. (area code)
Street Address	City, State, and Zip Code	County

CAUSE OF DISCRIMINATION BASED ON (Check appropriate box (es)	DATE MOST RECENT OR CONTINUING DISCRIMINATION TOOK PLACE (month, day, year)
[ ] RACE [ ] COLOR [ ] SEX [ ] RELIGION [ ] DISABILITY [ ] NATIONAL ORIGIN [ ] AGE [ ] MARITAL STATUS [ ] RETALIATION	

THE PARTICULARS ARE (If additional space is needed, attach extra sheet(s):

I. Personal Harm:

II. Respondent's Reasons for Personal Harm:

III. Discrimination Statement:

I REQUEST TO BE AFFORDED FULL RELIEF TO WHICH I AM ENTITLED UNDER THE LAW(S).

I will advise the agency if I change my address or telephone number and I will cooperate fully with them in the processing of my charge in accordance with their procedures.

Under penalties of perjury, I declare that I have read the foregoing charge of discrimination and that the facts stated in it are true.

SIGNATURE OF COMPLAINANT DATE

AFFIDAVIT

I, _____ hereby say:

I have been given assurances by a representative of the Florida Commission on Human Relations that this Affidavit will be considered confidential by the Agency and the U. S. Equal Employment Opportunity Commission, if applicable, and will not be disclosed as long as the case remains open unless it becomes necessary for them to produce the Affidavit in a formal proceeding. Upon the closing of this case, the Affidavit may be subject to disclosure in accordance with Agency policies.

I am _____ years of age; my gender is _____; my racial identity is _____; my social security number is _____; and my date of birth is _____.

I reside at: _____
(Number/Street)

_____
(City) (State) (County) (Zip Code)

My telephone number is (including area code):_____

My complaint is against:_____,

which is located at _____
(Number/Street)

_____
(City) (State) (County) (Zip Code)

Telephone number is (including area code):_____

Personnel Director is _____. The

Corporate office is located at:_____
(Number/Street)

_____
(City) (State) (County) (Zip Code)

Telephone Number (including area code):_____

My job classification is/was/applying for:_____
(Job Title)

My immediate supervisor is/was:_____
(Name/Job Title)

AFFIDAVIT continued

Please provide the following information:

a. An exact diary of the events leading to the problem. Be very specific as to dates, times and persons involved.

b. Make a list of all persons having direct knowledge of the problems leading to or involved in your complaint. Include their names, addresses, telephone numbers, and the nature of the information they can provide.

c. If you are filing based on a disability/handicap, please state your disability/handicap, and provide a statement from your doctor.

DO NOT WRITE ON BOTH SIDES OF PAGES WHEN RESPONDING BUT ADD MORE SHEETS IF NECESSARY. IF MORE SHEETS ARE ADDED, PLEASE BE SURE THE PAGE WHERE THE NOTARY SIGNS IS THE LAST PAGE INDICATED; THEREFORE, THE ENTIRE PACKAGE WILL BE SWORN TO