OMB Number 2900-0662
Estimated burden: 15 minutes

Department of Veterans Affairs

CIVIL RIGHTS DISCRIMINATION COMPLAINT

USE AN ADDITIONAL SHEET OF PAPER TO ANSWER ANY QUESTION IF NECESSARY.

PRIVACY ACT INFORMATION: The information requested on this form is solicited under authority of Title 38, Code of Federal Regulations, Chapter 1, Parts 15 and 18, and is used by patients and other VHA customers to file a formal complaint for alleged violations of their civil rights pertaining to race, color, sex, national origin, age, disability, or reprisal. The information you supply may also be disclosed outside the VA as permitted by law or as stated in the "Notices of Systems of VA Records" 16VA026 Litigant, Tort Claimant, EEO Complainant, and Third Party Recovery Files-VA and 63VA05 Grievance Records-VA published in the Federal Register. Disclosure is voluntary, however; failure to furnish the information will result in our inability to process your request promptly and adjudicate your grievance needs. Failure to furnish the information will have no adverse effect on any other benefits to which you may be entitled.

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of this Act. The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Completion of this form is entirely voluntary. Failure to complete the form will have no adverse impact on any benefits to which you may have been entitled. The purpose of this information collection is to help you explain an event you consider discriminatory.

1. NAME *(Last, First, Middle Initial)*

2. MAILING ADDRESS

3A. WORK TELEPHONE NO. *(Include area code)*

3B. HOME TELEPHONE NO. *(Include area code)*

4. NAME AND ADDRESS OF VA FACILITY OR OTHER AGENCY WHERE DISCRIMINATION OCCURRED.

5. NAME OF SERVICE/PRODUCT LINE WHERE DISCRIMINATION OCCURRED.

6. NAME OF INDIVIDUAL *(If known)* WHO DISCRIMINATED *(Include phone number)* OR IDENTIFY THE DISCRIMINATORY PRACTICE.

7. DATE OF DISCRIMINATION *(Include the most recent date(s)*

8. BASIS (For each claim you believe was discriminatory, list the bases for your complaint) *(You may list one or more)*:

- ☐ A. RACE *(Specify below)*
  - ◯ American Indian
  - ◯ Asian
  - ◯ White
  - ◯ Native Hawaiian or Other Pacific Islander
  - ◯ Black or African American
- ☐ B. COLOR / ETHNICITY *(Specify below)*
  - ◯ Spanish / Hispanic / Latino
  - ◯ Not Spanish / Hispanic / Latino
- ☐ C. NATIONAL ORIGIN
  - *(Specify)*
- ☐ D. SEX
  - ◯ Male ◯ Female
- ☐ E. AGE
  - *(Date of birth)*
- ☐ F. DISABILITY
  - ◯ Physical ◯ Mental

9. ISSUE(S) *(If your complaint concerns discrimination in the delivery of services, or employment, briefly describe what happened below.)*

10. LIST THE MOST CONVENIENT TIME AND PLACE FOR YOU TO BE CONTACTED REGARDING THIS COMPLAINT

11. PLEASE PROVIDE THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR ATTORNEY OR REPRESENTATIVE *(If applicable)*.

12. IF THE DISCRIMNATORY ACT DESCRIBED ABOVE OCCURRED MORE THAN 180 DAYS AGO, PLEASE EXPLAIN WHY YOU WAITED UNTIL NOW TO FILE A COMPLAINT.

13. LIST ANY PERSON *(Witness, fellow employee)* WHO CAN SUPPORT YOUR ALLEGATION *(List name, address, telephone number)*

14. HAVE YOU FILED THIS COMPLAINT WITH ANOTHER AGENCY? *(If yes, provide the name and address)* ☐ YES ☐ NO

15 . WHAT REMEDY ARE YOU SEEKING FOR THE ALLEGED DISCRIMINATION LISTED ABOVE?

16. SIGNATURE

17. DATE *(mm/dd/yyyy)*