MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
MISSOURI COMMISSION ON HUMAN RIGHTS
3315 West Truman Blvd.
Room 212
P.O. Box 1129
Jefferson City, MO 65102-1129

MISSOURI COMMISSION ON HUMAN RIGHTS

INTAKE QUESTIONNAIRE
Employment Complaints

Please immediately complete this form and return it to the Missouri Commission on Human Rights (MCHR). **REMEMBER**, a complaint of discrimination must be filed within the time limits imposed by law, generally within 180 days of the alleged act of discrimination. Upon receipt, this form will be reviewed to determine MCHR coverage. **ANSWER ALL QUESTIONS *that pertain to your situation*, as completely as possible, and attach additional pages if needed to complete your response(s). If you do not know the answer to a question, answer by stating "not known." If a question is not applicable to your situation, write "n/a." Please print.**

PERSONAL INFORMATION			
Last Name	First Name	M.I.	
Street or Mailing Address		Apt. or Unit #	
City	County	State	ZIP
Home Phone Number	Work Phone Number		
Cell Phone Number	E-mail Address		
Date of Birth	Sex ☐ Male ☐ Female	Do you have a disability? ☐ Yes ☐ No	

Please answer the next 3 questions.

1. Are you Hispanic or Latino?
☐ Yes ☐ No

2. What is your race? *(Please choose all that apply.)*
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African-American
☐ White
☐ Native Hawaiian or Other Pacific Islander

3. What is your National Origin? *(country of origin or ancestry)*

Please provide the name of a person we can contact if we are unable to reach you.

Name	Relationship	
Address		
City	State	ZIP
Home Phone Number	Other Phone Number	

COMPLAINT INFORMATION
4. I believe that I was discriminated against by the following organization(s): *(Check those that apply)* ☐ Employer ☐ Union ☐ Employment Agency ☐ Other *(Please specify):*

5. Organization Contact Information

Organization #1 Name

Address | County

City | State | ZIP

Phone Number | Type of Business

Number of Employees in the Organization at All Locations *(Please check one)*

☐ 0-5 ☐ 6-15 ☐ 15+

Are there employees of the organization in other states? ☐ Yes ☐ No

Organization #2 Name

Address | County

City | State | ZIP

Phone Number | Type of Business

Number of Employees in the Organization at All Locations *(Please check one)*

☐ 0-5 ☐ 6-15 ☐ 15+

Are there employees of the organization in other states? ☐ Yes ☐ No

6. What is the reason (basis) for your claim of employment discrimination?

For example, if you are over the age of 40 and feel you were treated worse than younger employees or you have other evidence of discrimination, you should check Age. If you feel that you were treated worse than those not of your race or you have evidence of discrimination, you should check Race. If you feel the adverse treatment was due to multiple reasons, such as your sex, religion and national origin, you should check all three. If you complained about discrimination, participated in someone else's complaint or if you filed a charge of discrimination and a negative action was threatened or taken because of that, you should check Retaliation.

☐ Race/Color ☐ Sex ☐ Age ☐ Disability ☐ National Origin ☐ Religion ☐ Retaliation ☐ Pregnancy
☐ Sexual Harassment ☐ Other reason (basis) for discrimination *(Explain):*

7. Background on the alleged discrimination. Which of the following employment action(s) were taken against you? *(Check only those that apply.)*

☐ Discharged
☐ Laid Off
☐ Suspended
☐ Harassed
☐ Disciplined
☐ Transferred
☐ Demoted
☐ Not Hired
☐ Not Promoted
☐ Not Recalled from Layoff
☐ Denied Benefits (Leave, Insurance, etc.)
☐ Denied Pay Raise
☐ Denied Religious Accommodation
☐ Other _____

8. Explain what happened to you below and include the date(s) of harm, action(s) and the name(s) and title(s) of the persons who you believe discriminated against you.
(Example: 10/02/06 – Written Warning from Supervisor, Mr. John Soto)

A. Date | Action

Name of Person(s) Responsible

Title of Person(s) Responsible

B. Date | Action

Name of Person(s) Responsible

Title of Person(s) Responsible

Describe any other actions you believe were discriminatory. *(Attach additional pages, if needed to complete your response.)*

What reason(s) were given to you for the acts you consider discriminatory? By whom? Title?

9. Name and describe others who were in the same situation as you. Explain any similar or different treatment. Who was treated better, and who was treated the same? Provide race, sex, age, national origin, religion, and/or disability status of comparator if known and if connected with your claim of discrimination. *(Add additional sheets, if needed.)*

1.	Full Name	Job Title
	Description	
2.	Full Name	Job Title
	Description	
3.	Full Name	Job Title
	Description	

10. Have you previously filed a charge in this matter with EEOC or another agency? ☐ Yes ☐ No
If "Yes," provide name or agency and date of filing.

11. If you are claiming discrimination based on disability, answer the following questions. If not, proceed to end to sign and date questionnaire. *(Please check all that apply.)*

☐ Yes, I have an actual disability
☐ I have had an actual disability in the past
☐ No disability but the organization treats me as if I am disabled

If you are alleging discrimination because of your disability, what is the name of your disability? How does your disability affect your daily life or work activities, e.g., what does your disability prevent or limit you from doing, if anything? *(Example: lifting, sleeping normally, breathing normally, pulling, walking, climbing, caring for yourself, working, etc.).*

Did you ask your employer for any assistance or change in working conditions because of your disability?
☐ Yes ☐ No

Describe the assistance or change in working conditions requested?

I understand that this questionnaire is not a complaint form and that I have not yet filed a complaint of discrimination. I understand that MCHR will review this form and if the information constitutes a basis for filing a complaint, a complaint will be mailed to me for signature. In order to preserve your rights, your signed complaint will need to be received at MCHR within 180 days of the alleged act of discrimination. I understand that a copy of the complaint form I sign will be sent to the employer, union or employment agency and will be the basis for the MCHR investigation.

_____ _____

Signature *Date*