

## FORMAL COMPLAINT OF DISCRIMINATION

*(Read information on the back of Copy 3 carefully before completing this form.)*

NOTE: IF YOU WISH TO FILE A FORMAL COMPLAINT OF DISCRIMINATION BASED ON RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN, AGE, HANDICAP, OR REPRISAL; COMPLETE THIS FORM.

1. COMPLAINANT INFORMATION	2. EMPLOYMENT INFORMATION
a. NAME <i>(Last, First, MI)</i>	a. TYPE <i>(Check one)</i> <input type="checkbox"/> GSA <input type="checkbox"/> FEDERAL <input type="checkbox"/> FORMER GSA <input type="checkbox"/> NON-FEDERAL
b. HOME ADDRESS <i>(Street, City, State, ZIP Code)</i>	b. NAME OF PROGRAM OFFICE
c. HOME TELEPHONE NUMBER (      )	c. OFFICE ADDRESS <i>(Street, City, State, ZIP Code)</i>
d. <del>SOCIAL SECURITY NUMBER</del>	d. OFFICE TELEPHONE NO. (      )
3. POSITION TITLE/SERIES/GRADE	

4. CHECK BASIS(ES) YOU BELIEVE CAUSED THE DISCRIMINATION			
a. RACE <i>(State type)</i>			
b. COLOR <i>(State type)</i>		f. HANDICAP <i>(Check one)</i>	
c. RELIGION <i>(State type)</i>		<input type="checkbox"/> PHYSICAL <i>(State type below)</i>	<input type="checkbox"/> MENTAL <i>(State type below)</i>
d. NATIONAL ORIGIN <i>(State type)</i>		g. AGE <i>(State years)</i>	DATE OF BIRTH
e. SEX <i>(Check appropriate boxes)</i> <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> EQUAL PAY <input type="checkbox"/> SEXUAL HARASSMENT		k. REPRISAL	

5. DESCRIPTION OF DISCRIMINATION (Explain, briefly, how you believe you were discriminated against *(that is, treated differently from other employees or applicants because of your race, color, religion, sex, national origin, age, mental or physical handicap, or reprisal)*. If your complaint involves more than one allegation of discrimination: (1) list each allegation; (2) provide the date(s) of alleged discriminatory act(s); and (3) furnish specific factual information in support of each. Use additional blank sheets of paper, if necessary.

6a. NAME OF EEO COUNSELOR	6b. TELEPHONE NUMBER (      )
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### 7. REPRESENTATION

a. NAME OF REPRESENTATIVE	b. TITLE <i>(Attorney, Union, etc.)</i>	c. TELEPHONE NUMBER (      )
d. ADDRESS <i>(Street, City, State, ZIP Code)</i>		

8. STATE REMEDY SOUGHT IN THIS COMPLAINT

9a. SIGNATURE OF COMPLAINANT	9b. DATE
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### DO NOT WRITE BELOW THIS LINE *(For Agency Use Only)*

AGENCY DOCKET NUMBER	DELIVERED BY <i>(Check one)</i>	DATE OF DELIVERY
NAME OF COMPLAINANT	<input type="checkbox"/> MAIL <i>(Include date of postmark)</i>	
	<input type="checkbox"/> HAND DELIVERY	
	<input type="checkbox"/> OTHER <i>(Specify)</i>	
SIGNATURE OF RECEIVING OFFICIAL	DATE	