

Hillsborough County's Equal Opportunity Administrator's Office
INTAKE QUESTIONNAIRE

1. Your Name (*Please Print*): (First) _____ (Middle) _____ (Last) _____

Address _____ City _____ State _____ Zip _____

Phone Numbers: Home: (_____) _____ Work: (_____) _____ Mobile: (_____) _____

Best Telephone Number to Contact You: _____

Email Address: _____

2. If the harm or action taken against you was in **Employment**, please complete the following:

I believe I was discriminated against by the following organization(s): (Check those that apply)

____ Employer _____ Union _____ Employment Agency _____ Other (please specify) _____

Does the organization employ 5 or more full time employees (include all location/branches/offices)? ___ Yes ___ No ___ Not Sure

Your employment Information: (complete as many items as you are able.)

Date Hired: _____ Job Title at Hire: _____ Job Title at Discrimination: _____

Date Quit/Discharged: _____ Name and Title of Immediate Supervisor: _____

If Job Applicant, Date Applied for Job: _____ Job Title Applied for: _____

If the harm or action taken against you was in **Housing**, please complete the following:

I believe I was discriminated against by the following person/entity:

____ Owner _____ Builder _____ Sales Person/Realtor _____ Manager _____ Bank or other Lender _____ Other: _____

What type of property was involved?

____ Single Family House _____ A house or building for 2,3,4 families _____ A building for 5 families or more

____ Other: _____

7. What happened to you that you believe was discriminatory? Include the date(s) of harm, the action(s), and the name(s) and title(s) of the person(s) you believe discriminated against you. **Please explain on an additional sheet of paper if necessary and sign and date all attachments.**

Describe in detail how you were treated differently because of your actual or perceived race, color, sex, age, national origin, religion, disability, marital status, familial status, sexual orientation, or gender identity or expression; or how you were retaliated against or sexually harassed. **Please explain on an additional sheet of paper if necessary and sign and date all attachments.**

Do you believe you were treated differently from people outside your protected class? Provide the race, color, national origin, sex, disability, familial status or religion of these individuals, if known,, and if it relates to your claim of discrimination

Do you have a disability, which is a physical or mental impairment that substantially limits a major life activity, such as caring for yourself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working? Please check all that apply:

Yes, I have a disability.

I do not have a disability now, but I did have one.

No disability, but the organization treats me as if I am disabled.

No disability, but the organization is aware that I am caring for a disabled individual.

8. IDENTIFY THE WITNESSES WHO HAVE FIRSTHAND KNOWLEDGE REGARDING THE INCIDENTS YOU HAVE DESCRIBED IN THIS COMPLAINT: (Please use additional paper if there are more than two witnesses and sign and date all attachments.)

Witness Name: _____

Telephone Number: (_____) _____ - _____

Relationship to Complainant (if any): _____

What does the witness know? _____

Witness Name: _____

Telephone Number: (_____) _____ - _____

Relationship to Complainant (if any): _____

What does the witness know? _____

Witness Name: _____

Telephone Number: (_____) _____ - _____

Relationship to Complainant (if any): _____

What does the witness know? _____

9. HAS THIS ALLEGATION BEEN FILED ANYWHERE ELSE? (For example, EEOC, Florida Commission on Human Relations, HUD, etc.)

_____ Yes _____ No

If yes, provide the following information:

Name of Agency: _____

Contact Person: _____

Telephone Number:(_____) _____-_____ Date of Filing: _____

Have you sought help about this situation from a union, an attorney or any other source? _____ Yes _____ No

If yes, provide the following information:

Name of organization: _____

Name of the person you spoke with: _____

Date of contact: _____

Result or outcome, if any: _____

PLEASE SIGN AND DATE THIS FORM

I declare that I have read this complaint (including any attachments, if applicable) and that it is true and correct.

Signature (Complainant)

Date

Please return this EOA Intake Questionnaire to:

Hillsborough County's Equal Opportunity Administrator's Office
700 E. Twiggs Street
Suite 830
Tampa, FL 33602

OR

You may fax it to : (813) 276-2217