

**CITY COLLEGES OF CHICAGO  
DISCRIMINATION AND HARASSMENT COMPLAINT FORM**

**Personal Information** [Please Print]

Name \_\_\_\_\_

Employee  Student  Other \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number: \_\_\_\_\_

\_\_\_\_\_

Email Address: \_\_\_\_\_

**Incident Information**

Location \_\_\_\_\_

[Location where incident(s) occurred]

Date \_\_\_\_\_

[Date incident(s) occurred]

**The name of the individual I am filing this complaint against is:**

\_\_\_\_\_  
Name

Employee  Student

**Name(s) and telephone number(s) of any known witness(es) to the incident(s):**

\_\_\_\_\_  
Name

Employee  Student

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Name

Employee  Student

\_\_\_\_\_  
Telephone Number

**Basis of Discrimination or Harassment** [Please specify all that apply]

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Race  | <input type="checkbox"/> Gender              | <input type="checkbox"/> Citizenship        | <input type="checkbox"/> Veteran Status           |
| <input type="checkbox"/> National Origin                                   | <input type="checkbox"/> Age                 | <input type="checkbox"/> Sexual Orientation | <input type="checkbox"/> Sexual Harassment        |
| <input type="checkbox"/> Ethnicity   | <input type="checkbox"/> Religion            | <input type="checkbox"/> Marital Status     | <input type="checkbox"/> Retaliation              |
| <input type="checkbox"/> Disability  | <input type="checkbox"/> Genetic Information | <input type="checkbox"/> Sexual Assault     | <input type="checkbox"/> Dating/Domestic Violence |
| <input type="checkbox"/> Membership or participation<br>in an organization | <input type="checkbox"/> Pregnancy           | <input type="checkbox"/> Other _____        |   |

Has an Incident Report been filed with a CCC Office of Safety and Security?  Yes  No If yes, Date: \_\_\_\_\_

Has a Police Report been filed?  Yes  No If yes, Date: \_\_\_\_\_ and Police District: \_\_\_\_\_

