



Government of the United States Virgin Islands

DIVISION OF PERSONNEL

Formal Discrimination/Sexual Harassment/Retaliation
COMPLAINT FORM

Please type or clearly print all information.

DATE FILED: _____

COMPLAINANT INFORMATION

LAST NAME (include: Sr./Jr./II, etc.)		FIRST NAME		MIDDLE NAME	
HOME ADDRESS			CITY	STATE	ZIP
HOME PHONE		WORK PHONE		CELL PHONE	
JOB TITLE		AGENCY		UNIT	
WORK E-MAIL ADDRESS					

COMPLAINANT STATUS (CHECK APPLICABLE BOX)☐ EMPLOYEE☐ VOLUNTEER☐ OTHERIf you check "other" specify whether: ☐ JOB APPLICANT ☐ VENDOR ☐ OTHER (CUSTOMER)**NAME AND TITLE OF PERSON(S) YOU BELIEVE DISCRIMATED AGAINST YOU**

NAME	JOB TITLE	AGENCY/UNIT
NAME	JOB TITLE	AGENCY/UNIT
NAME	JOB TITLE	AGENCY/UNIT

BASIS OF COMPLAINT (CHECK APPLICABLE BOX OR BOXES)

<input type="checkbox"/> RACE	<input type="checkbox"/> SEXUAL HARASSMENT	<input type="checkbox"/> ANCESTRY	<input type="checkbox"/> DISABILITY/ PERCEIVED DISABILITY	<input type="checkbox"/> AFFECTIONAL OR SEXUAL ORIENTATION
<input type="checkbox"/> SEX/GENDER	<input type="checkbox"/> AGE	<input type="checkbox"/> NATIONAL ORIGIN/ NATIONALITY	<input type="checkbox"/> GENDER IDENTITY OR EXPRESSION	<input type="checkbox"/> DOMESTIC PARTNERSHIP STATUS
<input type="checkbox"/> COLOR	<input type="checkbox"/> RETALIATION	<input type="checkbox"/> RELIGION/CREED	<input type="checkbox"/> MARITAL STATUS	<input type="checkbox"/> CIVIL UNION STATUS
<input type="checkbox"/> VETERAN STATUS OR LIABILITY FOR MILITARY SERVICE		<input type="checkbox"/> A TYPICAL HEREDITY CELLUALR OR BLOOD TRAIT	<input type="checkbox"/> USE OF GENETIC INFORMATION, INCLUDING REFUSAL TO SUBIT TO OR PROVIDE RESULTS OF GENETIC TEST	

DESCRIPTION OF COMPLAINT: List each incident separately and describe in detail the incident(s) and time and place of occurrence.

DESCRIPTION OF INCIDENT	DATE OF INCIDENT
	WAS INCIDENT REPORTED TO ANYONE? IF YES, WHO?
	DATE REPORTED
DESCRIPTION OF INCIDENT	DATE OF INCIDENT



	WAS INCIDENT REPORTED TO ANYONE? IF YES, WHO?
	DATE REPORTED
DESCRIPTION OF INCIDENT	DATE OF INCIDENT
	WAS INCIDENT REPORTED TO ANYONE? IF YES, WHO?
	DATE REPORTED
DESCRIPTION OF INCIDENT	DATE OF INCIDENT
	WAS INCIDENT REPORTED TO ANYONE? IF YES, WHO?
	DATE REPORTED
DESCRIPTION OF INCIDENT	DATE OF INCIDENT
	WAS INCIDENT REPORTED TO ANYONE? IF YES, WHO?
	DATE REPORTED
REMEDY SOUGHT (EXPLANATION)	
NOTE: The Complainant has a right to use the external procedures available under state law (Division on Civil Rights) and federal law (Equal Employment Opportunity Commission). Information regarding external procedures is contained in the Policy Statement and on posters located in Division of Personnel and Human Resources Office.	
COMPLAINANT'S SIGNATURE	Date
INVESTIGATOR SIGNATURE	Date
The completed form is to be given to a supervisor or Department Head.	

