**EMPLOYMENT DISCRIMINATION COMPLAINT FORM**
**Texas Workforce Commission Civil Rights Division**

Please return this form by:
Mail: 101 East 15th Street, #144T, Austin, TX 78778-0001
Email: EEOIntake@twc.state.tx.us
Telephone: (888) 452-4778 ***or***
Fax: (512) 463-2643 (Please include a cover sheet with your name and the total # of pages included.)

TWCCRD#_____

EEOC#_____

***Please indicate if you have previously filed this complaint with any of the agencies below:***

- ☐ Texas Workforce Commission Civil Rights Division (TWCCRD)
- ☐ Equal Employment Opportunity Commission (EEOC)
- ☐ City of Austin Equal Employment and Fair Housing Office
- ☐ Corpus Christi Human Relations Division
- ☐ Fort Worth Human Relations Department

**DATE RECEIVED (**For Office Use Only):

**Please be sure you provide all the information requested. For Assistance, send an E-mail to EEOIntake@twc.state.tx.us or call us at (888) 452-4778. (Ofrecemos asistencia en Español)**

**Complainant Full Name:**

**Address Line 1:**
**Address Line 2:**
**City/State/Zip:**
**Home Phone #:**
**Other Phone #:**
**Email:**

**Complainant Representative (Optional):** ***(If you are represented by an attorney, please have them submit a letter of representation)*:**

**Address Line 1:**
**Address Line 2:**
**City/State/Zip:**
**Phone #:**
**Fax #:**

**Preferred Form of Contact: (Please check)**
☐ **E-mail** ☐ **Telephone**

**Date Hired**: **Position held**:
**Still employed?** ☐ Yes ☐ No

**HR Personnel Officer/EEO Officer/or Highest Ranking Officer on work site:**

**Name of Employer** ***(Please be sure to give the complete Company name and address where you physically worked)***

**15 or more employees:**
☐ **Yes** ☐ **No**

**Company Address**
**Address Line 1:**
**Address Line 2:**
**City/State/Zip:**
**Phone #:**

**Company Officer Address**
**Address Line 1:**
**Address Line 2:**
**City/State/Zip:**
**Phone #:**

***BASIS:*** *I believe I have been discriminated against in violation of state law (Texas Labor Code, Chapter 21) and federal law (ADEA, GINA, Title VII, ADAAA), as follows*:

☐ **Age (*You must be 40 years of age or older to qualify*):**
Date of Birth:
_____/_____/_____
Month/day/year
Age at time of incident:
_____

☐ **Color** *(Based on skin color)*:
☐ Black
☐ Brown
☐ White
☐ Other:

☐ **Disability:**
☐ Disabled
☐ History of disability
☐ Regarded as disabled
***(Pregnancy is NOT a disability unless you are regarded as disabled.)***

***Please mark only the basis you believe were the reasons you were discriminated.***

☐ **GINA**
(Genetic Information Non-discrimination Act)

☐ **National Origin:**
☐ African-American
☐ Anglo/Caucasian
☐ East Indian
☐ Hispanic
☐ Mexican
☐ Other:

☐ **Race:**
☐ American Indian/Alaskan Native
☐ Asian/Pacific Islander
☐ Black
☐ White
☐ Other:

**EXAMPLE: If your treatment was because of your race, then check only the box by your race.**

☐ **Religion:**
☐ Baptist
☐ Catholic
☐ Jewish
☐ Muslim
☐ Other:

☐ **Retaliation**:
☐ Assisted another filing discrimination
☐ Filed a complaint of discrimination
☐ Participated in discrimination investigation.
***ON THIS DATE*:**
_____/_____/_____
Month/day/year

☐ **Sex:**
☐ Female
☐ Female/Pregnancy
☐ Male

| **Employment Harms or Actions (*Mark all that apply*)** | | |
|---|---|---|
| ☐ Demotion (D1)<br>☐ Discharge (D2)<br>☐ Discipline (D3)<br>☐ Harassment (H1)<br>☐ Hiring (H2) | ☐ Layoff (L1)<br>☐ Promotion (P3)<br>☐ Reasonable Accommodation (R6)<br>☐ Severance Pay (B5)<br>☐ Sexual Harassment (S4) | ☐ Suspension (S5)<br>☐ Terms & Conditions (T2)<br>☐ Training (T4)<br>☐ Wages (W1)<br>☐ Other: |

**The following questions are regarding the employment harms or actions taken against you.**
**(Each incident must be within 180 days of the date you submit your complaint to the TWCCRD.)**

**DATE(S) DISCRIMINATION TOOK PLACE (Month/Day/Year)**

Earliest (Month/Day/Year) ____/____/____ Latest (Month/Day/Year) ____/____/____ ☐ CONTINUING ACTION

| **Name and Position Title of person(s) who did the harm**: | **(If filing under race, color, national origin, religion, sex, age, please provide the race, color, national origin, religion, sex, or age of the person(s) discriminating against you:)** |
|---|---|
| | |

**Did you complain of discrimination to your employer**? ☐ **Yes** ☐ **No**

If Yes, date of complaint: ____/____/____ (Month/Day/Year)

**Name and Position Title of person(s) you complained to:**

**Explain why you believe the employment harm(s) and/or action(s) were discriminatory:**

**Employer's reason for its action**:

**Are there other employees treated more fairly than you?** ☐ **Yes** ☐ **No**

If Yes, please provide the information below:

| **Full Name and Position Title** | (If filing under race, color, national origin, religion, sex, and/or age, please provide the race, color, national origin, religion, sex, or age of the person(s) treated more fairly than you.) |
|---|---|
| | |
| | |
| | |

**What are you seeking as a resolution to your case?**

**What is the most convenient method to contact you:**

☐ Email: ☐ Telephone: ( )

_____ _____

**Signature** **Date**