EEO COMPLAINT FORM

If an individual believes that they have received unequal treatment or discrimination while receiving services from Audrain Developmental Disability Services (ADDS) or employment. ADDS will make efforts to resolve complaints at the lowest level possible.
To file a complaint, please complete this form. If you require assistance with completing the form, please contact our office at 573-581-8210.

Name: _____

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Email address: _____

Basis of complaint (please circle all that apply):

Race	Color	Religion	National Origin
Sex/Gender	Sexual Orientation	Gender Identity	Age
Disability	Retaliation	Other, please specify _____	

Who discriminated against you?

Name: _____

Name of Organization: _____

Address: _____

Phone: _____

How were you discriminated against? (Attach additional pages if more space is required.)

_____

_____

_____

_____

_____

_____

_____

_____

Where did the discrimination occur?

_____

_____

_____

Date and time discrimination occurred?

_____

_____

_____

Were there any other witnesses to the discrimination? If so, please list

Name: _____

Organization: _____

Phone: _____ Home: _____ Work: _____

Name: _____

Organization: _____

Phone: _____ Home: _____ Work: _____

How would you like to see the situation resolved?

_____

_____

_____

_____

_____

Please attach any written materials or other information that may be relevant to your complaint.

Print Name _____

Signature _____ Date _____

Witness Print Name _____

Witness Signature _____ Date _____