



COLLEGE of CHARLESTON

OFFICE OF EQUAL OPPORTUNITY PROGRAMS

Discrimination/Harassment Complaint Form

Once you have returned this completed and signed form to the designated personnel, your complaint will be properly received by the College. You will receive a copy of your completed form as well as complete information about the complaint process.

Check one: Faculty Staff Student Employment Applicant Other

Name Employee/Student ID Department

Work Telephone Home Telephone E-mail Address

Home Address

Job Title Hire Date Supervisor's Name and Telephone

Have you brought this matter to the attention of any other department(s) at the College? ____ If so, please list the name(s) and department(s) of all other persons with whom you have discussed this matter:

Type of Complaint - Check all that apply: Age Disability Equal Pay Genetic Information Gender Identity or Expression/Sexual Orientation National Origin Pregnancy Race/Color Religion Retaliation Sex Sexual Harassment Veteran status Other Harassment (Specify Type _____) Other (Specify _____)

Briefly summarize your complaint here. (Please also complete and attach the detailed Statement document and include supporting documents, including, but not limited to photos, video, recordings, e-mails, text messages, etc.)

List the person(s) you believe harassed or discriminated against you and relationship to you (e.g. supervisor, co-worker, faculty, student)

Describe any corrective action you seek.

Witnesses and relationship to you (e.g., friend, student, supervisor, co-worker, and faculty) Please attach additional pages if needed.

1. Name Relationship Telephone

2. Name Relationship Telephone

3. Name Relationship Telephone

I CERTIFY THAT THE INFORMATION CONTAINED ON THIS FORM, INCLUDING ALL ATTACHMENTS, IS TRUE AND CORRECT.

Print Name Signature Date

For the CofC Office of Equal Opportunity Programs - Complaint taken by:

Print Name Signature Date