HUMAN RIGHTS DISCRIMINATION INTAKE QUESTIONNAIRE

NORTH DAKOTA DEPARTMENT OF LABOR

SFN 52974 (Rev. 05-2002)

OFFICE USE ONLY
Date Received:

PLEASE PRINT

The information requested on this form will help us to help you. There is no guarantee that the information submitted will constitute a basis for filing a formal complaint. Please check or answer **all** questions that apply.

Name: (first, middle, last)					
Address: (number and street)	Apt. no:	City:	State:	Zip code:	County:
Home telephone number and area code:		Work telephone number and area code:			Ext.:
Name of person to contact if you cannot be reached:				Telephone number and area code:	

THE DISCRIMINATION WAS BECAUSE OF:

Check ALL that apply

- ☐ Race: _____ (What is your race?)
- ☐ Color: _____ (What is your color?)
- ☐ Religion_____ (What is your religion?)
- ☐ Sex ☐M ☐F (Check One)
- ☐ National origin: _____ (What is your national origin?)
- ☐ Age*

*If AGE discrimination, provide date of birth

- ☐ Disability _____ (What is your disability?)
- ☐ Marital status _____ (Specify)
- ☐ Pregnancy
- ☐ Status with regard to receipt of public assistance
- ☐ Retaliation
- ☐ Other_____

THE ACT(S) OF DISCRIMINATION WERE RELATED TO:

Check ALL that apply

- ☐ Denial of service
- ☐ Denial of accommodations
- ☐ Denial of credit
- ☐ OTHER

_____

_____

_____

_____

_____

BUSINESS OR SERVICE PROVIDER YOU BELIEVE DISCRIMINATED AGAINST YOU:

Name of business or service provider:			Telephone number and area code:	
Address:	City:	State:	Zip code:	County:
Contact person: (owner, manager, official)	Title:		Telephone number and area code:	

LIST THE NAMES AND TELEPHONE NUMBERS (IF POSSIBLE) OF WITNESSES YOU FEEL COULD PROVIDE EVIDENCE IN YOUR SUPPORT: (ATTACH STATEMENTS FROM WITNESSES IF AVAILABLE.)

(1) Name of witness:			Telephone number and area code:	
Address:	City:	State:	Zip code:	County:
(2) Name of witness:			Telephone number and area code:	
Address:	City:	State:	Zip code:	County:
(3) Name of witness:			Telephone number and area code:	
Address:	City:	State:	Zip code:	County:

BRIEFLY EXPLAIN how and/or why you feel discriminated against (how you were treated differently from others), by whom, when, and where. Be sure to indicate all dates (month, day, year) and names as accurately as possible. **If filing on the basis of disability, please provide appropriate medical documentation.**

IF MORE SPACE IS NEEDED, PLEASE ATTACH ADDITIONAL SHEETS

What reasons, if any, were you given for the action you are reporting?
Who gave you these reasons?

OTHER ACTIONS:

Have you filed with the United States Department of Justice or any other agency or group? ☐ Yes ☐ No	Name of agency:	Telephone number and area code:	
Address: (number and street)	City:	State:	Zip code:
Name of person who assisted you:			
What has this person done for you on this problem?			
Do you plan to take this matter to court? ☐ Yes ☐ No ☐ Undecided	Do you have an attorney? ☐ Yes ☐ No		
Name of attorney:		Telephone number and area code:	
Address: (number and street)	City:	State:	Zip code:

REMEDIES YOU ARE SEEKING FOR RELIEF:

I LEARNED ABOUT THE HUMAN RIGHTS DIVISION DISCRIMINATION PROGRAM FROM: (Be specific)

I ATTEST THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF

Signature:	Date: