SERVICE DELIVERY DISCRIMINATION COMPLAINT FORM

(Call Tom Madsen 715-524-4611 if you need assistance with this form.)

Name of Complainant _____
Address _____
City, State, Zip Code _____

BASIS FOR DISCRIMINATION COMPLAINT:
(Such as age, race, religion, color, disability, sex, or national origin.)

NAME OF AGENCY AND/OR PERSON AGAINST WHOM THE COMPLAINT IS FILED:

DESCRIPTION OF THE ACTION OR TREATMENT WHICH YOU THINK WAS DISCRIMINATORY: Include information about who, what, why, where, how, and the names, addresses and telephone numbers of any witnesses, if you know them. Be specific about the date of the last incident. You may use additional sheets if necessary. Indicate how many pages are attached if you need to add pages.

DESCRIPTION OF THE RELIEF OR SATIFACTION YOU WANT:

COMPLAINANT'S SIGNATURE_____ DATE_____
(COMPLAINANT OR COMPLAINANT'S REPRESENTATIVE)

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Received by _____ Actions/Individuals to be investigated.
Title _____ _____
Agency_____ _____
Date _____ _____
Attached report of findings/recommendations for further action (if required) to this page (completed within 30 days).

A written response was sent to the Complainant by _____ on _____.