



LOUISIANA COMMISSION ON HUMAN RIGHTS
OFFICE OF THE GOVERNOR

Post Office Box 94094
Baton Rouge, Louisiana 70804-9094
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INTAKE QUESTIONNAIRE

Please immediately complete the entire form and return it to the Louisiana Commission on Human Rights ("LCHR"). **REMEMBER**, a charge of employment discrimination must be filed within the time limits imposed by law, generally within 180 days or in some places 300 days of the alleged discrimination. Upon receipt, this form will be reviewed to determine LCHR coverage. **Answer all questions as completely as possible, and attach additional pages if needed to complete your response(s). If you do not know the answer to a question, answer by stating "not known." If a question is not applicable, write "n/a."**

(PLEASE PRINT)

1. Personal Information

Last Name: _____ First Name: _____ MI: _____

Street or Mailing Address: _____ Apt Or Unit #: _____

City: _____ County: _____ State: _____ Zip: _____

Phone Numbers: Home: (____) _____ Work: (____) _____

Cell: (____) _____ Email Address: _____

Date of Birth: _____ Sex: Male ___ Female ___ Race: _____

National Origin / Ethnicity _____ Do You Have a Disability? Yes No

Provide The Name Of A Person We Can Contact If We Are Unable To Reach You:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Other Phone: (____) _____

I believe that I was discriminated against by the following organization(s): (Check those that apply)

Employer _____ Union _____ Employment Agency _____ Other (Please Specify) _____

2. Organization Contact Information

Organization #1 Name: _____

Address: _____ **County:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone :(____)** _____

Type of Business: _____ **Job Location if different from Org. Address:** _____

Human Resources Director or Owner Name: _____ **Phone:** _____

Number of Employees in the Organization at All Locations: Please Check (✓) One

Less Than 15 15 – 100 101 – 200 201 – 500 More 500

Organization #2 Name: _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____ Phone :(____) _____

Type of Business: _____ Job Location if not at Org. Address: _____

Human Resources Director or Owner Name: _____ Phone: _____

Number Of Employees In The Organization At All Locations: please check (✓) one

Less Than 15 15 – 100 101 – 200 201 – 500 More 500

3. Your Employment Data (Complete as many items as you can)

Date Hired: _____ Job Title At Hire: _____

Pay Rate When Hired: _____ Last or Current Pay Rate: _____

Job Title at Time of Alleged Discrimination: _____

Name and Title of Immediate Supervisor: _____

If Applicant, Date You Applied for Job _____ Job Title Applied For _____

4. What is the reason (basis) for your claim of employment discrimination?

*FOR EXAMPLE, if you are over the age of 40 and feel you were treated worse than younger employees **or** you have other evidence of discrimination, you should check (✓) **AGE**. If you feel that you were treated worse than those not of your race **or** you have other evidence of discrimination, you should check (✓) **RACE**. If you feel the adverse treatment was due to multiple reasons, such as your sex, religion and national origin, you should check all three. If you complained about discrimination, participated in someone else's complaint or if you filed a charge of discrimination and a negative action was threatened or taken, you should check (✓) **RETALIATION**.*

Race Sex Age Disability National Origin Color Religion Retaliation Pregnancy

Other reason (basis) for discrimination (Explain). _____

5. What happened to you that you believe was discriminatory? Include the date(s) of harm, action(s) and include the name(s) and title(s) of the persons who you believe discriminated against you. (Example: 10/02/06 – Written Warning from Supervisor, Mr. John Soto)

A) Date: _____ Action: _____

Name and Title of Person(s) Responsible: _____

B) Date: _____ Action: _____

Name and Title of Person(s) Responsible _____

Describe any other actions you believe were discriminatory.

(Attach additional pages if needed to complete your response.)

6. What reason(s) were given to you for the acts you consider discriminatory? By whom? Title?

7. Name and describe others who were in the same situation as you. Explain any similar or different treatment. Who was treated worse, who was treated better, and who was treated the same? Provide race, sex, age, national origin, religion, and/or disability status of comparator if known and if connected with your claim of discrimination. Add additional sheets if needed.

Full Name	Job Title	Description
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Answer questions 8-10 only if you are claiming discrimination based on disability. If not, skip to question 11.

8. Please check all that apply:
- Yes, I have an actual disability
 - I have had an actual disability in the past
 - No disability but the organization treats me as if I am disabled

9. If you are alleging discrimination because of your disability, what is the name of your disability? How does your disability affect your daily life or work activities, e.g., what does your disability prevent or limit you from doing, if anything? (Example: lifting, sleeping normally, breathing normally, pulling, walking, climbing, caring for yourself, working, etc.).

10. Did you ask your employer for any assistance or change in working condition because of your disability?
YES NO

Did you need this assistance or change in working condition in order to do your job?
YES NO

If "YES", when? _____ To whom did you make the request? Provide full name of person _____ How did you ask (verbally or in writing)? _____ Describe the assistance or change in working condition requested?

11. Are there any witnesses to the alleged discriminatory incidents? If yes, please identify them below and indicate what they will say. Add additional pages if necessary.

A. **NAME** **JOB TITLE** **ADDRESS & PHONE NUMBER**

B. **NAME** **JOB TITLE** **ADDRESS & PHONE NUMBER**

C. **NAME** **JOB TITLE** **ADDRESS & PHONE NUMBER**

12. Have you filed a charge previously in this matter with EEOC or another agency? YES NO

13. If you have filed a complaint with another agency, provide name of agency and date of filing:

14. Have you sought help about this situation from a union, an attorney, or any other source?

YES NO - If yes, from whom and when? Provide name of organization, name of person you spoke with and date of contact. Results, if any?

Signature

Today's Date

If you have not heard from an EEOC office within 30 days of mailing this form, please call the number shown on top of this form. Please make a copy of this form for your records before mailing.

PRIVACY ACT STATEMENT: This form is covered by the Privacy Act of 1974: Public Law 93-579. Authority for requesting personal data and the uses thereof are:

- 1. **FORM NUMBER/TITLE/DATE.** EEOC/FEPA Intake Questionnaire (10/2006).
- 2. **AUTHORITY.** 42 U.S.C. § 2000e-5(b), 29 U.S.C. § 211, 29 U.S.C. § 626. 42 U.S.C. 12117(a)
- 3. **PRINCIPAL PURPOSE.** The purpose of this questionnaire is to solicit information in an acceptable form consistent with statutory requirements to enable the Commission to act on matters within its jurisdiction. When this form constitutes the only timely written statement of allegations of employment discrimination, the Commission will, consistent with 29 CFR 1601.12(b) and 29 CFR 1626.8(b), consider it to be a sufficient charge of discrimination under the relevant statute(s).
- 4. **ROUTINE USES.** Information provided on this form will be used by Commission employees to determine the existence of facts relevant to a decision as to whether

the Commission has jurisdiction over allegations of employment discrimination and to provide such charge filing counseling as is appropriate. Information provided on this form may be disclosed to other State, local and federal agencies as may be appropriate or necessary to carrying out the Commission's functions. Information may also be disclosed to respondents in connection with litigation.

5. **WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL FOR NOT PROVIDING INFORMATION.** The providing of this information is voluntary but the failure to do so may hamper the Commission's investigation of a charge of discrimination. It is not mandatory that this form be used to provide the requested information.

COMPLAINANT'S CONSENT FOR INVESTIGATORY USE OF PERSONAL INFORMATION

1. **I understand that I am not required to give personal information to the LCHR; however, my complaint may be closed if I refuse to supply information needed to investigate my complaint;**
2. **I understand that it is my duty to update the personal information I supply and failure to do so may result in my complaint being closed;**
3. **I understand that I may receive a copy of any personal information I submit, if I request it; and**
4. **I understand that the information provided by me may have to be released under the Public Records Request.**

Based on the foregoing, I hereby give my consent to LCHR to process my complaint.

Signature

Date

NOTE: THE LOUISIANA COMMISSION ON HUMAN RIGHTS RESERVES THE RIGHT TO MODIFY THIS FORM WITHOUT NOTICE OR CONSENT.