

**Hillsborough Community College
Complaint Intake Form**

Current Date

This Complaint Intake Form is used to report conduct that you believe violates HCC's rules and policies associated with discrimination, sexual misconduct, including sexual harassment, and retaliation. When completed, submit the form and any attachments to the Office of Equity and Diversity, 39 Columbia Drive, Suite 728, Tampa, FL 33606 or via e-mail all documents to equity@hccfl.edu. (Available in alternate formats upon request.).

1) COMPLAINANT'S INFORMATION

(If only reporting, go to #5):

Last Name
 First Name
 ID #
 Position Title
 Unit Campus/Dept.
 Home Address
 City State Zip Code
 Supervisor
 Phone Number
 Email
 Classification: Faculty Visitor
 Staff Other, please state:
 Student
 Applicant

RESPONDENT'S INFORMATION (Person you believe responsible for the violation):

Last Name
 First Name
 ID #
 Position Title
 Unit Campus/Dept.
 Home Address
 City State Zip Code
 Supervisor
 Phone Number
 Email
 Classification: Faculty Visitor
 Staff Other, please state:
 Student
 Vendor

2) BASIS OF THE COMPLAINT: (Check all appropriate items. Discrimination or Harassment Complaint must be based on protected class status.)

Sex	Age	Race/Ethnicity	Harassment	Genetic Information
M F	Religion	National Origin	Sexual Violence	Retaliation
L G	Color	Marital Status	Sexual Harassment	Sexual Orientation
B T	Disability	Military Status	Sexual Misconduct	Gender Identity/Expression
	Pregnancy			

3) Check those actions which you believe the Respondent, Faculty Member, Staff, or Supervisor took or failed to take because of the basis of this complaint. More than one action may be checked.

Hiring	Wage	Hazing	Job Benefits	Sabbath Observance	Other, please fill in:
Recall	Promotion	Bullying	Intimidation	Pregnancy Related	
Layoff	Demotion	Due Process	Termination	Segregated Facilities	
Travel	Seniority	Free Speech	Job Assessment	Training/Apprenticeship	
Education		Dropped Course			

4) DATE OF VIOLATION OCCURRED: (The date of the most recent complained of conduct violation).

5) WITNESSES/ REPORTERS: Please provide the names of individuals with first-hand (knowledge maybe knowledge of the alleged violation).

Name				Name			
Address				Address			
City	State	Zip Code		City	State	Zip Code	
Phone Number				Phone Number			

6) THE COMPLAINT. Describe in detail the alleged discrimination/retaliatory act(s). Please make sure to include the following, at a minimum:

- Why you believe the act(s) was/were because of your status and why you believe the act(s) was/were status activity and retaliation;
- Dates, places, names and titles of persons involved and witnesses, if any;
- What harm, if any, was caused to you or others with whom you work as a result of the alleged discriminatory act(s); and
- What explanation, if any, was offered for the act(s) by the respondent?

If this complaint is based on disability, describe the medical condition, date you were diagnosed, and nature of discrimination based on disability.

What happened:

When:

Harm Caused:

Explanation from the accused, if any:

7) RELIEF SOUGHT. (i.e., reinstatement of job, removal of discipline, change in assignment, grade change, etc.)

8) FILE ELSEWHERE: If you have filed this complaint or a similar one elsewhere, (i.e., as a labor grievance with an immediate supervisor, with a department head/chairperson, with an outside agency etc.). please tell us:

Name and Contact

Address

City

State

Zip Code

Email

Phone Number

9) SIGNATURE AND VERIFICATION

I affirm that, to the best of my knowledge or belief, the information contained herein is true and accurate. I understand that completion of this intake form or the filling of a complaint does not extend the time for filing a complaint with an outside agency, or court of law. Additionally, I understand that the effective date of filing this complaint is the date this form is physically received by the Office of Equity and Diversity (OED). I further understand that any person who knowingly provides frivolous, false or fraudulent information in an OED complaint may be subject to discipline. If applicable, I hereby authorize the release of any medical information needed for the investigation. I acknowledge Florida's Broad Public Records Law and understand that this document may be subject to disclosure. However, certain information will be redacted to protect any party to this dispute.

Signature of Charging Party

Date