Program Discrimination Complaint Form

Instructions: Please fill out this form completely. Sign it and return to the address on page 3.

Complainant Name: ____________________________________________________________
Address: ________________________________________________________________
City, State, Zip Code: ______________________________________________________
Home: ________________________________________________________________
Cell: ________________________________________________________________
Work: _______________________________________________________________
Email ________________________________________________________________

Person making the complaint on behalf of the complainant

Name: ________________________________________________________________
Address: ________________________________________________________________
City, State, Zip Code: ______________________________________________________
Home: ________________________________________________________________
Cell: ________________________________________________________________
Work: ________________________________________________________________

Name of company/organization complaint is against:
_____________________________________________________________________
_____________________________________________________________________

MDCH is an Equal Opportunity Employer, Services and Programs Provider
Address: ________________________________________________________________

City, State, Zip Code__________________________

Telephone Number: ________________________________

Complaint Information:

When did this event occur (date)?

_____________________________________________________________________

Describe the event, providing the name(s) where possible for the people who were involved.
Use additional pages if necessary.

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MDCH is an Equal Opportunity Employer, Services and Programs Provider
Has a complaint been filed with the Michigan Department of Civil Rights or the US Department of Justice, or any other Federal Agency or Court on this same matter?

Yes___  No ___
If yes, Agency or Court: _________________________________________________
Date Filed: _______

Do you plan to file with another agency or court?

Yes____  No  _______
If yes, when:____________________________________________________________

Signature & Date

SIGNATURE:________________________________________DATE________

Return to:

Toya Williams, EEO Officer
Michigan Department of Community Health
320 S. Walnut St.
1st Floor
Lansing, MI. 48913
Tel. 517-335-4276
Fax. 517-373-7123
Email: williamst8@michigan.gov
Website:  http://www.michigan.gov/mdch/0,4612,7-132-2946_5111_15720---,00.html