

Coppin State University Complaint Form

This complaint form is to be utilized for reporting conduct that is believed to be in violation of Coppin State University's Fair Practices policies. Once completed, please return to the Office of Human Resources.

<p>1. COMPLAINANT— Person who alleges the violation of Fair Practices policies:</p> <p>Last Name: _____</p> <p>First Name: _____</p> <p>Primary Role on Campus: <input type="checkbox"/> Faculty <input type="checkbox"/> Student <input type="checkbox"/> Third Party</p> <p style="padding-left: 40px;"><input type="checkbox"/> Staff <input type="checkbox"/> Other, please state: _____</p> <p>Position/Title: _____</p> <p>School/Dept.: _____</p> <p>Home Address: _____</p> <p>City: _____ State: _____ Zip Code: _____</p> <p>Phone Number: _____</p> <p>Email: _____</p>	<p>RESPONDENT— Person you believe to be responsible for alleged violation of Fair Practices Policies:</p> <p>Last Name: _____</p> <p>First Name: _____</p> <p>Primary Role on Campus: <input type="checkbox"/> Faculty <input type="checkbox"/> Student <input type="checkbox"/> Third Party</p> <p style="padding-left: 40px;"><input type="checkbox"/> Staff <input type="checkbox"/> Other, please state: _____</p> <p>Position/Title: _____</p> <p>School/Dept.: _____</p> <p>Home Address: _____</p> <p>City: _____ State: _____ Zip Code: _____</p> <p>Phone Number: _____</p> <p>Email: _____</p>
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2. BASIS OF YOUR COMPLAINT: What is the reason for your claim of discrimination/sexual misconduct? (Please check all applicable items.)

Age Ancestry Color Disability Gender Expression
 Gender Identity Genetic Information Harassment Marital Status National Origin
 Political Affiliation Pregnancy Race/Ethnicity Religion Reprisal/Retaliation
 Sex Sexual Harassment Sexual Misconduct Sexual Orientation Title IX
 Veteran Status Other, please state: _____

If you checked color, religion or national origin, please specify: _____

If you checked genetic information, how did the respondent obtain the genetic information: _____

What type of genetic information is involved: Genetic Testing Family medical history Genetic services

3. ADVERSE ACTION AGAINST YOU: Indicate action(s) you believe the Respondents took or failed to take because of age, ancestry, color, disability, gender expression/identity, genetic information, marital status, national origin, political affiliation, pregnancy, race/ethnicity, religion, sex, sexual harassment/misconduct/orientation, Title IX, veteran status, or other protected category. (Please check all applicable items.)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Academic Grievance | <input type="checkbox"/> Access to program/activity | <input type="checkbox"/> Accommodation to Disability | <input type="checkbox"/> Award |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Demotion | <input type="checkbox"/> Evaluation | <input type="checkbox"/> Exclusion from program/activity |
| <input type="checkbox"/> Grade Assignment | <input type="checkbox"/> Harassment | <input type="checkbox"/> Hazing | <input type="checkbox"/> Hiring |
| <input type="checkbox"/> Intimidation | <input type="checkbox"/> Job Assignment | <input type="checkbox"/> Job Benefits | <input type="checkbox"/> Layoff |
| <input type="checkbox"/> Pregnancy Leave | <input type="checkbox"/> Promotion | <input type="checkbox"/> Recall | <input type="checkbox"/> Religious Observation |
| <input type="checkbox"/> Segregated Facilities | <input type="checkbox"/> Seniority | <input type="checkbox"/> Suspension | <input type="checkbox"/> Termination |
| <input type="checkbox"/> Testing | <input type="checkbox"/> Training | <input type="checkbox"/> Wages | <input type="checkbox"/> Working Conditions |
| <input type="checkbox"/> Other, please state:
_____ | | | |

4. INFORMATION ABOUT THE INCIDENT(S): Provide general information about your allegations.

Date conduct occurred: (please provide the date of the last alleged act of discrimination.) _____

Number of Incidents: _____ Name of Supervisor or Manager aware of your allegations: _____

Witness 1: Name _____ Title/Role/Department: _____

Witness 2: Name _____ Title/Role/Department: _____

Witness 3: Name _____ Title/Role/Department: _____

Witness 4: Name _____ Title/Role/Department: _____

Witness 5: Name _____ Title/Role/Department: _____

5. NATURE OF THE COMPLAINT: On the next page, explain as briefly and clearly as you can what happened and how you believe you were discriminated/retaliated against. Please be sure to include the following, at a minimum:

- Why you believe you were discriminated/retaliated against;
- What harm, if any, was caused to you or others as a result of the alleged discriminatory act(s);
- Dates, places, names and titles or persons involved and witnesses, if any;
- How you believe other persons were treated differently from you;
- What explanation, if any, was offered for the act(s) by the respondent(s);
- Attach any written documentation pertaining to this matter.

If this complaint is based on disability, please describe the disability, your history of disability, or why you think you were regarded as disabled.

I believe that I have been subjected to a discriminatory practice and/or sexual misconduct because (if necessary, attach additional sheets):

Have efforts been made to resolve this complaint with a supervisor or official?

Yes No

If yes, please indicate the individual(s), date of complaint, and the status of the complaint.

6. HAVE YOU FILED A PREVIOUS COMPLAINT?

Yes No

If so, please describe the incident, when it occurred, when you filed the complaint, and the status of the complaint.

Who did you file this complaint with?

CSU EEOC MCCR OCR Other _____

Do you have a representative?

Yes No

If so. Please provide your representative's name and contact information.

Is your representative an attorney?

Yes No

7. RELIEF SOUGHT: What remedy(ies) do you seek to resolve this complaint to your satisfaction? (i.e., stop inappropriate behavior, reinstatement of job or status in academic program, removal of discipline, change or removal of academic record or grade etc.)

NOTICE CONCERNING YOUR RIGHTS TO FILE A COMPLAINT WITH A CIVIL RIGHTS ENFORCEMENT AGENCY

Any employee or applicant for employment who believes he or she has experienced discrimination has a right to file a formal complaint with a federal or State civil rights enforcement agency. *A person does not give up this right when he or she files a complaint with the University's Office of Human Resources..*

The following federal and State agencies enforce laws against discrimination:

- **Maryland Commission on Civil Rights (MCCR)**
6 St.Paul Street, 9th Floor
Baltimore, Maryland 21202
Phone: 410-767-8600
- **U.S. Equal Employment Opportunity Commission (EEOC)**
10 South Howard Street, 3rd Floor
Baltimore, Maryland 21201
Phone: 410-962-3932

THE FOLLOWING STATUTORY TIME PERIODS FOR THE TIMELY FILING OF A CHARGE OF DISCRIMINATION APPLY (TIME PERIOD IS MEASURED FROM THE DATE OF OCCURRENCE OF A DISCRIMINATORY ACTION):

1. Maryland Commission on Civil Rights – Six months - (Title 20, Subtitle 6, State Government Article, Annotated Code of Maryland)
2. U.S. Equal Employment Opportunity Commission – 300 days

Confidentiality – Information obtained as part of an investigation is confidential and disclosure of any investigatory information is subject to the provisions of Title 10, Subtitle 6 of the State Government Article, Annotated Code of Maryland.

AFFIRMATION

I affirm that I have read the above notice concerning my rights to file a complaint with a federal, state, or local civil rights enforcement agency at anytime before or after I file an internal complaint with the University's Office of Human Resources, and that I am aware of the filing deadlines for those agencies.

Signature

Date

(Please provide a copy of this form to the Complainant)

8. SIGNATURE AND VERIFICATION: I affirm to the best of my knowledge or belief, the information contain herein is true and factual. Additionally, I understand that the effective date of filing this complaint is the date this form is physically received by the Office of Human Resources, I further understand that any person who knowingly provides frivolous, false or fraudulent information in a Fair Practices complaint may be subject to discipline. If applicable, I hereby authorize the release of any medical information needed for the investigation.

Signature of Complainant: _____ Date: _____

OHR USE ONLY:

Received by: _____

Signature: _____

Received date: _____

Respondent(s) notification date: _____

Investigative Report/Decision date: _____

Was Report/Decision Appealed? Yes No

Appeal Date: _____

Final Decision Date: _____

Complaint Filed with External Agency? Yes
 No

Agency's Name: _____

Date: _____

List all attachments received with form: