

**EMPLOYMENT DISCRIMINATION COMPLAINT FORM****Texas Workforce Commission Civil Rights Division**

Please return this form by:

Mail: 101 East 15th Street, Guadalupe CRD, Austin, TX 78778-0001

Email: [EEOIntake@twc.state.tx.us](mailto:EEOIntake@twc.state.tx.us)

Telephone: (888) 452-4778 or

Fax: (512) 482-8465 (Please include a cover sheet with your name and the total # of pages)

TWCCRD# \_\_\_\_\_

EEOC# \_\_\_\_\_

***Please indicate if you have previously filed this complaint with any of the agencies below:***

- Texas Workforce Commission Civil Rights Division (TWCCRD)  
 Equal Employment Opportunity Commission (EEOC)  
 City of Austin Equal Employment and Fair Housing Office  
 Corpus Christi Human Relations Division  
 Fort Worth Human Relations Department

**DATE RECEIVED** (For Office Use Only):

Please be sure you provide all the information requested. For Assistance, send an E-mail to [EEOIntake@twc.state.tx.us](mailto:EEOIntake@twc.state.tx.us) or call us at (888) 452-4778. (Ofrecemos asistencia en Español)

**Complainant Full Name:****Address Line 1:****Address Line 2:****City/State/Zip:****Home Phone #:****Other Phone #:****Email:****Complainant Representative (Optional):** *(If you are represented by an attorney, please have them submit a letter of representation):***Address Line 1:****Address Line 2:****City/State/Zip:****Phone #:****Fax #:****Preferred Form of Contact: (Please check)** E-mail  Telephone**Date Hired:** \_\_\_\_\_ **Position held:** \_\_\_\_\_**Still employed?**  Yes  No**HR Personnel Officer/EEO Officer/or Highest Ranking Officer on work site:****Name of Employer** *(Please be sure to give the complete Company name and address where you physically worked)***15 or more employees:** Yes  No**Company Address****Address Line 1:****Address Line 2:****City/State/Zip:****Phone #:****Company Officer Address****Address Line 1:****Address Line 2:****City/State/Zip:****Phone #:**

**BASIS:** *I believe I have been discriminated against in violation of state law (Texas Labor Code, Chapter 21) and federal law (ADEA, GINA, Title VII, ADA), as follows:*

**Age** *(You must be 40 years of age or older to qualify):*

Date of Birth:

\_\_\_\_/\_\_\_\_/\_\_\_\_

Month/day/year

Age at time of incident:

\_\_\_\_\_

 **Color** *(Based on skin color):* Black Brown White Other: **Disability:** Disabled History of disability Regarded as disabled*(Pregnancy is NOT a disability unless you are regarded as disabled.)*

**Please mark only the basis you believe were the reasons you were discriminated.**

**GINA** *(Genetic Information Non-discrimination Act)*

 **National Origin:** African-American Anglo/Caucasian East Indian Hispanic Mexican Other: **Race:** American Indian/Alaskan Native Asian/Pacific Islander Black White Other:

**EXAMPLE: If your treatment was because of your race, then check only the box by your race.**

 **Religion:** Baptist Catholic Jewish Muslim Other: **Retaliation:** Assisted another filing discrimination Filed a complaint of discrimination Participated in discrimination investigation.**ON THIS DATE:**

\_\_\_\_/\_\_\_\_/\_\_\_\_

Month/day/year

 **Sex:** Female Female/Pregnancy Male

**Employment Harms or Actions** (Mark all that apply)

- Demotion (D1)
- Discharge (D2)
- Discipline (D3)
- Harassment (H1)
- Hiring (H2)

- Layoff (L1)
- Promotion (P3)
- Reasonable Accommodation (R6)
- Severance Pay (B5)
- Sexual Harassment (S4)

- Suspension (S5)
- Terms & Conditions (T2)
- Training (T4)
- Wages (W1)
- Other:

**The following questions are regarding the employment harms or actions taken against you.  
(Each incident must be within 180 days of the date you submit your complaint to the TWCCRD.)**

**DATE(S) DISCRIMINATION TOOK PLACE (Month/Day/Year)**

Earliest (Month/Day/Year)

Latest (Month/Day/Year)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

CONTINUING ACTION

**Name and Position Title of person(s) who did the harm:**

**(If filing under race, color, national origin, religion, sex, age, please provide the race, color, national origin, religion, sex, or age of the person(s) discriminating against you:)**

**Did you complain of discrimination to your employer?**  Yes  No

If Yes, date of complaint: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Month/Day/Year)

**Name and Position Title of person(s) you complained to:**

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**Explain why you believe the employment harm(s) and/or action(s) were discriminatory:**


**Employer's reason for its action:**


**Are there other employees treated more fairly than you?**  Yes  No

If Yes, please provide the information below:

**Full Name and Position Title**

(If filing under race, color, national origin, religion, sex, and/or age, please provide the race, color, national origin, religion, sex, or age of the person(s) treated more fairly than you.)


**What are you seeking as a resolution to your case?**

**What is the most convenient method to contact you:**

Email:  Telephone: (   )

\_\_\_\_\_

**Signature** \_\_\_\_\_

**Date**