| **SAN DIEGO WORKFORCE PARTNERSHIP**  **COMPLAINT FORM** | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **This form should be used by anyone who wishes to file a Program Grievance and/or Nondiscrimination & Equal Opportunity (EO) complaint against any person(s)/entity while involved in San Diego Workforce Partnership funded programs. To file a Program Grievance and/or Nondiscrimination & Equal Opportunity (EO) complaint complete this form, sign on a page 4, and return to the San Diego Workforce Partnership as follows:** | | | | | | | | | | | |
|  | | Molly Dishman - Equal Opportunity Officer/Grievance Officer | | | | | | |  | | |
|  | | San Diego Workforce Partnership, Inc. | | | | | | |  | | |
|  | | 9246 Lightwave Ave., Suite 210, San Diego, CA 92123 | | | | | | |  | | |
|  | | Phone: (619) 489 – 5355 ; TDD: (619) 528-1153  [complaints@workforce.org](mailto:complaints@workforce.org) | | | | | | |  | | |
| 1. **Complainant information** | | | | | | | | | | | |
| Miss  Ms.  Mrs.  Mr.  Other | | | | Home phone: | | ( ) |  | | | | |
| Work phone: | | ( ) |  | | | | |
| Cell phone: | | ( ) |  | | | | |
| Name: |  | | | | | | | | | | |
| Address: |  | | | | | | | | | | |
| City, State, ZIP: |  | | | | | | | | | | |
| Email Address: |  | | | | | | | | | | |
| 1. **Complainant contact information** | | | | | | | | | | | |
| When it is a convenient time during business hours (8 a.m. to 5 p.m.) to contact you by the phone about this complaint? | | | | | | | | | | | |
| **Day** | Monday | | Tuesday | | Wednesday | | | Thursday | | | Friday |
| **Time** |  | |  | |  | | |  | | |  |
| **Phone** |  | |  | |  | | |  | | |  |
| 1. **Contact information for the person(s)/entity(ies) you have a complaint against** | | | | | | | | | | | |
| **Provide the name of the entity where the person(s) work(s):** | | | | |  | | | | | | |
| Name(s) of person(s)/entity(ies): | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Address of person(s)/entity: | | | | | City, State, ZIP: | | | | | | |
|  | | | | |  | | | | | | |
| Phone number: | | | | | Date of first occurrence: | | | | |  | |
|  | | | | | Date of most recent occurrence: | | | | |  | |

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| 1. **Tell us about the incident(s)** | | | | | | | | | | |
| Explain briefly what happened:   * Provide the date(s) when the incident(s) occurred. * Indicate who your program grievance or discrimination complaint is against. Include names and titles, if possible. * If other people were treated differently than you, tell us how they were treated differently. * Attach any documents that you think might help us better understand your complaint. | | | | | | | | | | |
|  | | | | | | | | | | |
| 1. **Please list below any person(s)/witnesses that we may contact for additional information to support or clarify the complaint.** | | | | | | | | | | |
| **Name** | | | | | | **Address** | | | **Phone** | |
|  | | | | | |  | | |  | |
|  | | | | | |  | | |  | |
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| 1. **Basis for discrimination**   If this complaint involves discrimination, please check the type of discrimination you experienced. If you believe more than one basis was involved, you may check more than one box.  If this complaint does not involve discrimination, skip to question 7. | | | | | | | | | | |
|  | **Age** – *provide date of birth*: | | |  | | |  | **Citizenship** | | |
|  | **Color** | | | | | |  | **Disability** | | |
|  | **National origin** (Including Limited English Proficiency) | | | | | |  | **Religion** | | |
|  | **Retaliation** | | | | | |  | **Harassment** | | |
|  | **Gender** – *Specify* | F | | | M | |  | **Sex** *(including pregnancy, childbirth, or related medical conditions, gender, identity, and transgender status)* | | |
|  | **Race** – *indicate race:* | |  | | | |  | **Status as a program participant under the** ***Workforce Innovation Opportunity Act*** | | |
|  | **Political Affiliation or Belief** | | | | | |  | **Other** – *Specify:* | |  |

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| 1. **Have you previously filed a complaint against this person(s)/entity?**  **Yes**  **No** | | | | | | | | | | | | | | | | | | | | | |
| If **YES**, answer the questions below, if **NO** move to section 8 | | | | | | | | | | | | | | | | | | | | | |
| 1. Was your complaint in writing? | | | | | | | | | **Yes** | | | **No** | | | | | |  | | | |
| 1. On what date did you file the complaint? | | | | | | |  | | | | | | | | | | | | | | |
| 1. Name of office where you filed your complaint: | | | | | | | | |  | | | | | | | | | | | | |
| Address: | | | | |  | | | | | | | | | | | | | | | | |
| City, State, ZIP: | | | | |  | | | | | | | | | | | | | | | | |
| Phone number: | | | | |  | | | | | | | | | | | | | | | | |
| Contact person *(if known)*: | | | | |  | | | | | | | | | | | | | | | | |
| 1. Have you been provided a final decision on report? | | | | | | | | | | **Yes** | | | | **No** | | |  | | | | |
| If you marked **YES** please attach a copy of the complaint decision or report. | | | | | | | | | | | | | | | | | | | | | |
| 1. **What corrective action or remedy do you seek? Please explain:** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| 1. **Choosing a personal representative** | | | | | | | | | | | | | | | | | | | | | |
| * You may choose to have someone else represent you in dealing with this complaint. It may be a relative, friend, union representative, an attorney, or someone else. * If you choose to appoint someone to represent you, all of our communication to you will be routed through your representative. | | | | | | | | | | | | | | | | | | | | | |
| Do you want to authorize a personal representative to handle this complaint? | | | | | | | | | | | | | | | **Yes** | | | | **No** | |  |
| If **YES**, answer the questions below, if **NO** move to section 10. | | | | | | | | | | | | | | | | | | | | | |
| **AUTHORIZATION OF PERSONAL REPRESENTATIVE** | | | | | | | | | | | | | | | | | | | | | |
| I wish to authorize the individual identified below to act on my behalf as my personal representative, in matters such as mediation, settlement conferences, or investigations regarding this complaint. | | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | | | | | | | | | | | | | | |
|  | I am an attorney representing the complainant. | | | | | | | |  | | I am **not** an attorney representing the complainant. | | | | | | | | | | |
| Mailing Address: | | | |  | | | | | | | | | | | | | | | | | |
| City: | |  | | | | State: | |  | | | | | | | | ZIP code: | | | |  | |
| Phone: | | |  | | | | Fax: | | | | | |  | | | | | | | | |
| Email: | | |  | | | | | | | | | | | | | | | | | | |

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| 1. **Alternate Dispute Resolution (ADR) also known as Meditation.** | | | | | |
| **Notice:** You must indicate if you wish to mediate your case. The Equal Opportunity Officer/Grievance Officer of the San Diego Workforce Partnership cannot begin to process your complaint until you have made a selection. Please check “YES” or “NO” in the space below. | | | | | |
| * Mediation is an alternative to having your complaint investigated * Neither party loses anything by mediating. * The parties to the complaint review the facts, discuss opinions about the facts, and strive for an agreement that is satisfactory for both. * Agreement to mediate is not an admission of guilt by the person(s)/entity that you claim discriminated against you. * Mediation is conducted by a trained, qualified and impartial mediator. * You (or your Personal Representative) have control to negotiate a satisfactory agreement. * **Terms of the agreement are signed by the complainant and the person(s)/entity that you claim discriminated against you.** * **Agreements are legally binding on both sides.** * If an agreement is not reached, a formal investigation will start. * Failure to keep an agreement will result in a formal investigation. * A formal investigation will be opened if retaliation is reported. | | | | | |
| Do you wish to mediate your complaint? | | **Yes**, I want to mediate. | **No,** please investigate. | | |
| If you marked **YES,** you will be contacted within five (5) business days with more information. | | | | | |
| 1. **Complainant Signature** | | | | | |
| **You must sign this form for your complaint to be processed.**  **Faxed or otherwise electronically delivered complaints will be logged into our system; however, an official investigation cannot begin until the original, signed copy is received by our office.** | | | | | |
| By signing below, I attest all information contained in this grievance/complaint is true to the best of my knowledge. I request that the San Diego Workforce Partnership, Inc. take the necessary action to resolve this matter, and I release my personal records so that this matter may be thoroughly investigated. This release is only to the extent necessary to reasonably and fully investigate this matter and is not a general release of all my personal records. | | | | | |
| **Signature:** |  | | | **Date:** |  |