EMPLOYMENT DISCRIMINATION COMPLAINT FORM
Texas Workforce Commission Civil Rights Division

Email: EEOIntake@twc.state.tx.us
(888) 452-4778

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
- ☐ Fort Worth Human Relations Department
- ☐ Corpus Christi Human Relations Division

DATE RECEIVED (For Office Use Only):

Please be sure you provide all the information requested.

(For Spanish call (888) 452-4778)

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

Please mark only the basis you are filing under.

EXAMPLE: If your treatment was because of race – check the box by your race.

☐ **Age (*You must be 40 years of age or older to qualify*):** Date of Birth: Month/day/year Age at time of incident:	☐ **Race:** ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/ Alaskan Native ☐ Other	☐ **National Origin:** ☐ Anglo/Caucasian ☐ African-American ☐ Hispanic ☐ Mexican ☐ East Indian ☐ Other	☐ **Sex:** ☐ Male ☐ Female ☐ Female/Pregnancy ☐ **GINA** (Genetic Information Non-discrimination Act)
☐ **Religion:** ☐ Baptist ☐ Catholic ☐ Jewish ☐ Muslim ☐ Other	☐ **Color** *(Based on skin color)*: ☐ White ☐ Black ☐ Brown ☐ Other	☐ **Disability:** ☐ Disabled ☐ Regarded as disabled ☐ History of disability ***(Pregnancy is NOT a disability unless you are regarded as disabled.)***	☐ **Retaliation**: ☐ I filed a complaint of discrimination ☐ I assisted another filing discrimination ☐ I participated in an investigation of discrimination ***ON THIS DATE*:**

Please call our office at (888) 452-4778 if you need assistance completing this form.

Complainant Full Name:	**Complainant Representative (Optional):** ***(If you are represented by an attorney, please have them submit a letter of representation)*:**
Address Line 1:	**Address Line 1:**
Address Line 2:	**Address Line 2:**
City/State/Zip:	**City/State/Zip:**
Home Phone #:	**Phone #:**
Other Phone #:	**Fax #:**
Email:	

Date Hired: **Position held**: **Still employed?** ☐ Yes ☐ No

Name of Employer ***(Please be sure to give the complete Company name and address where you physically worked)***	**HR Personnel Officer/EEO Officer/or Highest Ranking officer on work site:**
Address Line 1:	**Address Line 1:**
Address Line 2:	**Address Line 2:**
City/State/Zip:	**City/State/Zip:**
Phone #:	**Phone #:**
15 or more employees: ☐ **Yes** ☐ **No**	**Fax #:**

Employment Harms or Actions (*Mark all that apply*)		
☐ Severance Pay (B5) ☐ Demotion (D1) ☐ Discharge (D2) ☐ Discipline (D3) ☐ Harassment (H1)	☐ Hiring (H2) ☐ Layoff (L1) ☐ Promotion (P3) ☐ Reasonable Accommodation (R6) ☐ Sexual Harassment (S4)	☐ Suspension (S5) ☐ Terms & Conditions (T2) ☐ Training (T4) ☐ Wages (W1) ☐ Other:

The following questions are regarding the actions taken against you. ***(Each incident must be within 180 days of the date you submit your complaint to the TWCCRD.)*** **Please call us at (888) 452-4778 if you need assistance completing this form.**

DATE OF FIRST HARM: _____
Explain what happened. (*Provide full names and position titles of all involved in this action.*)**:**

Reason Employer gave you for their actions:

Provide the full names of other employees treated *MORE FAIRLY* than you. (*If you filed under race give their race, if under sex, give their sex, etc.)***:**

DATE OF SECOND HARM: _____
Explain what happened. *(Provide full names and position titles of all involved in this action.):*

Reason Employer gave you for their actions:

Provide the full names of other employees treated *MORE FAIRLY* than you. (*If you filed under race give their race, if under sex, give their sex, etc.)***:**

DATE OF THIRD HARM: _____
Explain what happened. *(Provide full names and position titles of all involved in this action.)***:**

Reason Employer gave you for their actions:

Provide the full names of other employees treated *MORE FAIRLY* than you. (*If you filed under race give their race, if under sex, give their sex, etc.)***:**

If we draft your charge and send it to you at your email address, will you print, sign, and return the form that same day? ☐ Yes ☐ No

What is the most convenient method to contact you: ☐ Email: ☐ Telephone: ( )

What is the best time to contact you: a.m. p.m.
What is the best day of the week to contact you: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri

Do you agree to participate in our mediation program? ☐ Yes ☐ No

Please return this form by email to: **EEOIntake@twc.state.tx.us**
Please call (888) 452-4778 for assistance.
Mailing address: 101 East 15th Street, #144T, Austin, TX 78778-0001