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
Telephone: (888) 452-4778 ***or***
Fax: (512) 463-2643 or (512) 463-2755

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 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, ADAAA), 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:

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: ( )

Submitting this Complaint Form DOES NOT represent filing a formal Charge of Discrimination