

**City of Atlanta  
Human Relations Commission  
Complaint Form**

*Please be advised that this form is affected by the State of Georgia's Open Records Act,  
codified at O.C.G.A. 50-18-70 et seq.*

**PLEASE PRINT**

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Telephone No. (include area code): Work: \_\_\_\_\_ Home: \_\_\_\_\_  
Email: \_\_\_\_\_

**Do you have an attorney representing you in this matter? If yes,**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone No. (include area code): \_\_\_\_\_

**PLEASE PROVIDE THE NAME OF A PERSON AT A DIFFERENT ADDRESS WHOM WE  
CAN CONTACT IF WE ARE UNABLE TO REACH YOU:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Telephone No. (include area code): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Why do you believe that you were discriminated against (Check all that apply)**

Race            Color            Creed            Religion            Sex            Disability  
Domestic Relationship Status            Parental Status            Familial Status            Criminal History  
Sexual Orientation            National Origin            Gender Identity            Age

Use of a Trained Dog Guide by a Blind, Deaf or otherwise physically disabled person

**Please read the following information before proceeding:**

**Your Charge of Discrimination must be filed within 180 days after the alleged unlawful practice has occurred.**

Please complete this questionnaire and return to the Mayor's Office of Constituent Services (Suite 1920 in City Hall, 55 Trinity Avenue, SW). You may be interviewed by an investigator to find out if your problem falls within the jurisdiction of the Human Relations Commission.

**THE ENTITY THAT YOU BELIEVE DISCRIMINATED AGAINST YOU:**

Name:

Address:

City:

State:

Zip:

County:

Telephone No. (include area code):

**Have you filed a Complaint with the Human Relations Commission in the past [ ] NO [ ] YES  
(If YES, answer the following):**

Approximate date filed

Organization Charged

Charge No. (if known)

**THE FOLLOWING QUESTIONS CONCERN THE SPECIFIC ACTIONS(S) TAKEN AGAINST YOU.  
IF YOU NEED ADDITIONAL SPACE, PLEASE ATTACH SEPARATE PAGES AND NUMBER YOUR  
RESPONSES.**

**1. What action was taken against you that you believe to be discriminatory? What harm was caused to you and/or others in your work situation because of the action?**

**2. What is the date this action first occurred?**

**3. What is the last date?**

**4. Who took this action against you (*if known*)? Name(s) and Job titles(s)**

**5. What reason(s) were you given for the action taken?**

**6. Why do you think the action was discrimination? (Provide the name, job title, and department of employee(s) in the same or similar situation treated more favorable. Explain how they were treated differently.)**

**7. Provide all evidence and information in your possession of discriminatory treatment. The documents that would support what you said in item four, item five or item six (Attach any documents to the form.)**

**8. Provide the name(s), address(es), telephone number(s), and a description of the information that can be provided by your witness(es) who you think can provide evidence in support of your allegations of discrimination:**

<b>Name</b>	<b>Address</b>	<b>Telephone</b>	<b>Description of Information Witness Can Provide</b>
<b>a.</b>			
<b>b.</b>			
<b>c.</b>			
<b>d.</b>			
<b>e.</b>			