



Rowan Non-Discrimination Policy Complaint Form

Name: _____ Job Title: _____
Division/Department: _____ Extension #: _____
Home Address: _____
Phone: _____ Email: _____
Name of person(s) your complaint is against: _____
Person's Title and Department: _____
Date and time of incident: _____
Briefly describe what happened (add additional pages if necessary):

Basis of Discrimination: (choose all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Age | <input type="checkbox"/> Familial Status | <input type="checkbox"/> Race |
| <input type="checkbox"/> Affectional/Sexual Orientation | <input type="checkbox"/> Gender Identity or Expression | <input type="checkbox"/> Religion |
| <input type="checkbox"/> Ancestry | <input type="checkbox"/> Genetic Information (including refusal to submit to or provide results of a genetic test) | <input type="checkbox"/> Sex/Gender (including pregnancy) |
| <input type="checkbox"/> Atypical Hereditary Cellular or Blood Trait | | <input type="checkbox"/> Sexual Harassment |
| <input type="checkbox"/> Color | <input type="checkbox"/> Liability for Military Service | <input type="checkbox"/> Retaliation (for having filed a discrimination complaint, participating in a complaint investigation, or for opposing a discriminatory practice) |
| <input type="checkbox"/> Creed | <input type="checkbox"/> Marital /Civil Union Status | |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Nationality | |
| <input type="checkbox"/> Domestic Partnership Status | <input type="checkbox"/> National Origin | |

I certify that the above statement is given in good faith and is true and accurate to the best of my knowledge and belief.

Signature Date

Date