SERVICE DELIVERY OR EMPLOYMENT DISCRIMINATION COMPLAINT

If you need help completing this form please contact:

Name - Equal Opportunity Coordinator	Phone (Voice)	Phone (TDD)
Nickijo Hager	(608) 392-9440	

Name of Complainant	Phone Number
	( )

Address (number, street, city, state, zip code)

Basis for Service Delivery or Employment Discrimination Complaint : In service delivery, discrimination is prohibited on the following basis: Age, color, disability, national origin, religion, political belief or affiliation (apply to USDA-FNS programs only), race, sex or retaliation for filing a complaint, or for assisting with a complaint, opposing discrimination in a program, service or activity.

Employment discrimination is prohibited on the basis of: age (over 40), national origin or ancestry, arrest record, conviction record, color, creed or religion, disability or association with a person with a disability, genetic testing, honesty testing, marital status, pregnancy or childbirth, military service, race, sex, sexual orientation, use or non use of lawful products off the employer's premises during non-working hours. Employees may not be harassed in the workplace based on their protected status not retaliated against for filing a complaint, for assisting with a complaint, or for opposing discrimination in the workplace.

Name of the Agency and/or Employee or Employer Against Whom the Complaint is Filed

Describe the action or treatment that you think was discriminatory. Include information about who, what, when, where, how, why, and the names, addresses and phone numbers of any witnesses, if you know them. Please be specific about the date of the last incident. You may write this on another sheet of paper if you need more room. In the space below, please say how many pages are attached if you need to add pages.

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_____

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_____

Description of the Relief or Satisfaction you Want:_____

_____

_____

_____ _____

Signature of Complainant or Complainant Representative **Date Signed**

The information below is to be completed by Franciscan Skemp Healthcare and will respond to the complainant.

INFORMAL COMPLAINT FORM

Date Received	Received By	Title
Agency		

Actions and Individual(s) to be investigated: _____

_____

_____

Findings (must be completed within 30 days): _____

_____

_____

Action Taken: _____

_____

_____

Further Action Required? ☐ Yes ☐ No If yes, what action is recommended?

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