

Workplace Harassment Complaint Form

Employee information	
Name:	Phone Number:
Position:	Supervisor:
E-Mail Address:	
Harassment Complaint Information	
I was harassed because of my:	
<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Gender <input type="checkbox"/> Medical Condition <input type="checkbox"/> National Origin <input type="checkbox"/> Pregnancy <input type="checkbox"/> Race <input type="checkbox"/> Religion <input type="checkbox"/> Other (Explain below)	
Person (or persons) who harassed you or discriminated against you	
Name:	Position:
Please explain the incident or conduct that is the basis of this complaint and include where and when it took place. Attach additional pages, if required:	
Witnesses and contact information if known (e-mail and telephone numbers if you have them):	
Have you discussed this complaint with anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, list their contact information below.)	
Signatures	
Complainant:	Date:
Received By:	Date: