

Rockford Metropolitan Agency for Planning Title VI and Related Statutes Discrimination Complaint Form

Name	Telephone (home)	Telephone (work)
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Address:	City, State, Zip Code
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Name of MPO Staff Person that You Believe Discriminated Against You:

Address:	City, State, ZIP Code
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Date of Alleged Incident:

Cause of Discrimination:

<input type="checkbox"/> Race	<input type="checkbox"/> Retaliation	<input type="checkbox"/> Sex	<input type="checkbox"/> Familial Status	<input type="checkbox"/> Religion
<input type="checkbox"/> Color	<input type="checkbox"/> National Origin (Language)	<input type="checkbox"/> Age	<input type="checkbox"/> Disability	<input type="checkbox"/> Other

Explain clearly how discrimination occurred and who participated in discrimination. Include in your explanation any way that you feel you were treated unfairly. Attach any other writing that relates to your case.

Signature	Date
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