



Alameda-Contra Costa Transit District  
Equal Employment Opportunity/Mediation & Diversity

Case Number ACT:

DISCRIMINATION COMPLAINT FORM

**BASIS OF COMPLAINT** Please check as many that apply:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Race               | <input type="checkbox"/> Color          | <input type="checkbox"/> Religion                     | <input type="checkbox"/> Sex                             |
| <input type="checkbox"/> National Origin    | <input type="checkbox"/> Age            | <input type="checkbox"/> Disability (Mental/Physical) | <input type="checkbox"/> Ancestry                        |
| <input type="checkbox"/> Religious Creed    | <input type="checkbox"/> Marital Status | <input type="checkbox"/> Family Medical Leave         | <input type="checkbox"/> Pregnancy                       |
| <input type="checkbox"/> Sexual Orientation | <input type="checkbox"/> Retaliation    | <input type="checkbox"/> Medical Condition            | <input type="checkbox"/> Other, please specify:<br>_____ |

**REPRESENTATION**

Are you represented in this matter?

**Union**

- ATU Local 192
- IBEW Local 1245
- AFSCME Local 3916

**Attorney**

- Yes
- No

Other, please specify:

\_\_\_\_\_

\_\_\_\_\_

**SPECIFICS OF COMPLAINT**

Please describe in detail what happened. Who did what, when, where and is there any witnesses. Was the incident reported? If so, to whom and what was the response. What date or the most recent date did this discrimination occur? Please add additional sheets as needed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE OF CHARGING PARTY**

X \_\_\_\_\_

Date: \_\_\_\_\_

**CONTACT INFORMATION**

Home Telephone \_\_\_\_\_

Work Telephone \_\_\_\_\_

Cell Telephone \_\_\_\_\_

E-Mail \_\_\_\_\_