



CIVIL RIGHTS DIVISION

Charge Intake Form

Your Name:		
Street:		City:
State:	Zip:	County:
Home Phone:		Work Phone:
Email Address:		Cell Phone:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Age: _____ Date of Birth: _____
Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Other _____		National Origin: <input type="checkbox"/> American <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Other _____

Provide the name of the State or County Government Agency you believe discriminated against you:

Name of the Agency:				
Street:		City:		
State:	Zip:	County:		
Agency's telephone no. (with area code):				
Most recent date of alleged harm (that you believe was discrimination) to you:				
Do you think this happened to you because of your (check as appropriate):				
<input type="checkbox"/> Race	<input type="checkbox"/> Sex	<input type="checkbox"/> National Origin	<input type="checkbox"/> Disability	<input type="checkbox"/> Age (40 & over)
<input type="checkbox"/> Color	<input type="checkbox"/> Religion	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Retaliation	<input type="checkbox"/> Sexual Harassment
<input type="checkbox"/> Other _____				
In your own words, briefly describe what happened to you that you believe to be discriminatory. A short description of what happened will be enough at this time.				

Signature: _____

Date: _____

****You may submit this form via email to civilrightsdiv@oah.nc.gov****

****By completing this form you have not filed a charge of employment discrimination.****