

ALLEGED DISCRIMINATION COMPLAINT FORM
San Diego Community College District

Please check one: Employee ____, Student ____, or Member of the General Public ____

Print when completing this form:

NAME _____ DATE _____

Street or P.O. Box _____

City _____ Zip Code _____

TELEPHONE # _____

OTHER NUMBER WHERE YOU CAN BE REACHED _____

HOURS AVAILABLE _____

I WISH TO COMPLAIN AGAINST:

Name of Person, College/Program, or Activity _____

Address _____

Please check only those which apply to your allegation of discrimination:

(1) Age ____

(4) Disability: _____

(2) Ethnicity ____

Mental ____

(3) Gender (Sex) ____

Physical ____

Other (Specify) _____

OR

(1) Ancestry ____

(6) Political or Organizational

(2) Color ____ Affiliation ____

(3) Marital Status ____

(7) Religion _____

(4) *Medical Condition _____

(8) Sexual Harassment _____

(5) National Origin _____

(9) Sexual Orientation _____

(Medical condition includes any health impairment related to or associated with a diagnosis of cancer, for which a person has been rehabilitated or cured, based on competent medical evidence)

Please specify how you were discriminated against by stating the problem as you see it and by describing the incident, the participants, the background to the incident and any attempts you have made to solve the problem. Be sure to note relevant dates, times, and places.

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SDCCD Alleged Discrimination Complaint Form

Date of alleged discrimination: _____

If there is anyone who could provide more information regarding this, please list names, addresses, and telephone numbers.

NAME ADDRESS TELEPHONE NUMBER

THE PROJECTED SOLUTION: Indicate what you think can and should be done to solve the problem. Be as specific as possible.

I certify that this information is correct to the best of my knowledge.

Signature of Complainant _____ Date _____

Instructions:

Forward original copy to:
Affirmative Action Office
San Diego Community College District

3375 Camino del Rio South
San Diego, CA 92108