COMPLAINT QUESTIONNAIRE

Office of Civil Rights

PLEASE PRINT IN INK OR TYPE

NAME: ___________________________ PHONE NO.: __________________

ADDRESS: ___________________________

CITY: ___________________ STATE: _______ ZIP: ___________

PERSON (S), COMPANY OR ORGANIZATION YOU ARE COMPLAINING AGAINST:

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

AREA CODE/PHONE NUMBER: ______________________________

ADDRESS: ___________________________

CITY: ___________________ STATE: _______ ZIP: ___________

Please provide a brief statement of your complaint. Attach copies of any documents that support your statement. Do not send original documents. All documents and attachments submitted are subject to public inspection pursuant to Chapter 119, Florida Statutes.

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
List the address and telephone number of any witnesses who can verify your complaint.

1. ____________________________________________________________
   ____________________________________________________________

2. ____________________________________________________________
   ____________________________________________________________

3. ____________________________________________________________
   ____________________________________________________________

Signature __________________________________________ Date ____________

Please return this questionnaire to:
Office of the Attorney General
Office of Civil Rights
The Capitol PL-01
Tallahassee, FL 32399-1050
Telephone: 850.414-3300, Fax: 850.921-7671
Thank you!