COMPLAINT OF DISCRIMINATION IN EMPLOYMENT
MAINE HUMAN RIGHTS COMMISSION

I also want this filed with the U.S. Equal Employment Opportunity Commission (EEOC) ☐

I want this filed only with MHRC ☐

COMPLAINANT Name (indicate Mr., Ms., Mx.) *If more than 1, list under PARTICULARS below* | Best Contact Phone #

Mailing Address, including city, state and ZIP code | Email address

RESPONDENT(S) [This is the Employer, Labor Organization, Employment Agency, Apprenticeship Committee, or State or Local Government Agency That I Believe Discriminated Against Me.] *If more than 2, list under PARTICULARS below.*

RESPONDENT #1 Name | **# Employees/Mem.** | Phone # (with Area Code)

Mailing Address, including city, state and ZIP code

RESPONDENT #2 Name | **# Employees/Mem.** | Phone # (with Area Code)

Mailing Address, including city, state and ZIP code

CAUSE OF DISCRIMINATION based on: [*Check appropriate box(es)*]

☐Age [D.O.B. ____/____/____] ☐Religion ☐Whistleblowers' Retaliation
☐National Origin ☐Sex ☐MHRA Retaliation ☐Ancestry ☐Color
☐Physical or Mental Disability ☐ Workers' Compensation Retaliation
☐Sexual Orientation ☐ Race ☐Other (please specify): _____

DATE DISCRIMINATION TOOK PLACE

____/____/____ **Earliest date** ____/____/____ **Latest date**

CONTINUING ACTION? ____ if yes

***THE PARTICULARS ARE*:** *(If additional paper is needed, attach extra sheet(s))*

By signing below, I* agree: (1) I will not make public any information that I learn through the investigation of this complaint until the MHRC's investigation is complete, and (2) I will not make public at all the names of any third persons that I learn during investigation of this Complaint; and (3) I will advise the EEOC and MHRC if I change my contact information, and I will cooperate fully with them in the processing of my complaint in accordance with their procedures; and (4) if this case relates to a disability I will complete and sign the medical authorization on the second page of this Complaint. ***The signature must be that of the Complainant. The signature of an attorney is not acceptable.***

!THE FOLLOWING SECTION MUST BE COMPLETED IN THE COMPANY OF A LICENSED MAINE NOTARY/ATTORNEY!

I swear or affirm under penalty of perjury that the above complaint is true and correct to the best of my knowledge, information and belief.

Complainant signature: _____ **Date:** ____/____/_____

Notary/Attorney: Subscribed and sworn and subscribed before me, _____, this _____/____/_____ .
(Printed Name)

Signature of Notary Public/Attorney:_____ My Commission Expires:_____/_____/_____

COMPLAINAINT'S AUTHORIZATION FOR RESPONDENT(S)
TO RELEASE COMPLAINANT'S MEDICAL/HEALTH CARE INFORMATION
TO THE MAINE HUMAN RIGHTS COMMISSION

[MUST BE FILLED OUT BY COMPLAINANT IF COMPLAINT RELATES TO HIS/HER MENTAL OR PHYSICAL DISABILITY]

_____ v. _____
Complainant Name Respondent(s) Name

COMPLAINANT AGREES:

- In order to investigate my complaint of discrimination, I hereby authorize Respondent(s) to release to the Maine Human Rights Commission and its staff any and all medical or healthcare records or information concerning any of the following medical conditions that I am relying on as part of my complaint of discrimination:

_____

(***Complainant:*** ***FILL THIS OUT*** ***AND LIST ALL MEDICAL CONDITIONS YOU ARE RELYING ON RELATED TO THIS COMPLAINT OF DISCRIMINATION***)

- Respondent(s) may release information it has/had from ____/____/_____ to ____/____/_____ related to my medical condition.
↑ ***(Complainant:*** ***Fill out*** ***these dates)*** ↑
- I also authorize Respondent(s) and their employees or agents to speak with an investigator or attorney from the Commission concerning my medical condition.
- I understand that if these records or information include information regarding treatment or diagnosis of substance abuse, HIV infection or AIDS, they will also be released.
- I understand that the Commission will only seek records or other information pursuant to this release that it deems reasonably necessary to further the investigation of the above-referenced complaint. I also understand that, pursuant to the Maine Human Rights Act, all evidence collected during the investigation of the complaint, including records or information obtained pursuant to this release, other than data identifying persons not parties to the complaint, shall become a matter of public record at the conclusion of the investigation of the complaint prior to a determination by the commission.

This release expires upon (1) the completion of the Maine Human Rights Commission's investigation, prosecution, and processing of my complaint of discrimination, (2) my written request, or (3) three years from the signing of this release, whichever first occurs. Upon request, I will be provided with a copy of this signed release and any records obtained as result of this release. I understand subsequent disclosures may be made pursuant to this authorization until it expires or is revoked.

I have the right at any time to refuse or revoke authorization to disclose all or some medical information, but my refusal or revocation may result in the inability of the Commission to investigate and process my complaint. I can revoke this release by providing written notice to the Commission.

A photocopy of this authorization shall be considered as effective and valid as the original.

Date: X_____ Complainant: X_____

Maine Human Rights Commission
51 State House Station
Augusta ME 04333-0051 MHRC No. Assigned _____