

OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/AFFIRMATIVE ACTION

112 EAST POST ROAD, THIRD FLOOR WHITE PLAINS, NEW YORK 10601 TELEPHONE (914) 995-2141 TELEFAX (914) 813-4018

SEXUAL HARASSMENT COMPLAINT FORM

Date:		
Name:		
Department:		
Location/Unit:		
Name of your Supervisor:		
INDIVIDUAL(S) WHO ALLEO	GEDLY COMMITTED ACT OF SEX	UAL HARASSMENT/DISCRIMINATION AGAINST YOU:
Name:	Title:	Department/Unit:
		AINT OF CONDUCT ALLEGEDLY COMMITTED BY ED, ATTACH 8 ½ X 11 SHEET OF PAPER)

Please identify all employees or others who witnessed and/or have any knowledge conduct, describing what was witnessed and/or the nature of such knowledge:		
PLEASE ANSWER THE FOLLOWING QUESTIONS:		No:
Are there any documents, which contain information, supporting your complaint?		
s there any physical evidence which supports your complaint?		
Have you missed any work time as a result of this incident?		
Have you incurred any medical expenses?		
Have you previously complained about this or related acts thereof to a County supervisor or any other County official?		
f you answered yes, please identify the person(s) to whom you complained, the date	e(s) and the pl	ace:
What is seemed and seemed a decided the seemed in 49		
What is your requested remedy as to this complaint?		
(Print your name) (Signature)	Date:	
(Finit Jour name) (Signature)		

PERSONAL & CONFIDENTIAL CONTACT INFORMATION

Your Name:	
Work Telephone Number:	[] []
E-mail Address:	
Home Address:	