DEPARTMENT OF MENTAL HEALTH & ADDICTION SERVICES

FORM AA-100

Affirmative Action Grievance Form

Please complete the following:

Last Name:		**First Name:**	
Facility:		**Location/ Division:**	
Race:	**Sex:**	**Shift:**	**Days/Week:**
Position Title:			
Immediate Supervisor Name and Title:			
Telephone number(s) where you can be reached:		**Work#:**	
Home #:	**Cell#:**	**E-mail:**	

Mailing Preference (check which you prefer): ❒ **Work Address** ❒ **Home Address**

Work Address: (Street, City, State, Zip)	**Home Address:** If you prefer mail to your home address, please submit on a separate sheet. This information will be kept confidential.

Please check any applicable items below:

I believe that on _____ **(mm/dd/yyyy) I have been:** ❒ **Discriminated Against** ❒ **Harassed**
(Incident Date)

On the basis of: ❒ RACE ❒ COLOR ❒ RELIGIOUS CREED ❒ ANCESTRY ❒ AGE (DOB:_____) ❒ SEX
❒ SEXUAL HARASSMENT ❒ GENDER IDENTITY OR EXPRESSION ❒ MARITAL STATUS ❒ NATIONAL ORIGIN
❒ WORKPLACE HAZARDS TO REPRODUCTIVE SYSTEMS ❒ PRESENT / PAST HISTORY OF MENTAL DISABILITY ❒ RETALIATION
❒ INTELLECTUAL DISABILITY ❒ LEARNING DISABILITY ❒ PHYSICAL DISABILITY INCLUDING, BUT NOT LIMITED TO BLINDNESS
❒ PREGNANCY/ FAMILIAL STATUS ❒ GENETIC INFORMATION ❒ VETERAN STATUS ❒ SEXUAL ORIENTATION
❒ PRIOR CONVICTION OF A CRIME (subject to Sec. 46a-79, 46a-80 of C.G.S.)

COMPLETE THE FOLLOWING, ONLY IF APPLICABLE:

I believe that on _____ (mm/dd/yyyy) I was retaliated against by _____ (name) for previously opposing a discriminatory practice (Filing or testifying in an Affirmative Action Grievance, CHRO or EEOC grievance).

How was your employment affected? (check any that apply)

❒ FAILURE TO HIRE ❒ FAILURE TO PROMOTE ❒ DEMOTION ❒ TERMINATION ❒ SUSPENSION OR OTHER CORRECTIVE ACTION
❒ POOR SERVICE RATING ❒ DENIAL OF TRAINING OR ACCOMMODATION ❒ UNEQUAL TREATMENT (PLEASE DESCRIBE): _____
_____

Please complete page 2 and attach to this form, along with any other documentation.

❒ **I elect to resolve this through mediation if possible**
(Only in cases with no MHAS-20 Work Rule Violation or Affirmative Action investigations)

By signing below, I understand that I have the right to file my complaint with the Commission on Human Rights & Opportunities (CHRO), and/or the U.S. Equal Employment Opportunity Commission (EEOC), or with any other state, federal or local agency that enforces laws against discriminatory or illegal employment practices. I certify that the information provided herein is true to the best of my knowledge and belief:

_____ _____
Signature of Complainant **Date**

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Alleged Violator(s) / Respondent(s): (use separate paper if more space is needed)

NAME	TITLE	UNIT	PHONE #	SHIFT

Witnesses (if any): (use separate paper if more space is needed)

NAME	TITLE	UNIT	PHONE #	SHIFT

Please provide a detailed description of your grievance. Include dates, locations, and times of incidents. *(You may attach additional pages or any other relevant documentation, such as a completed MHAS-20 incident report if applicable).* **Please number allegations if possible.**

❒ **Remedy Requested / How can this be resolved?**

Signature of Complainant **Date**