Department of Health and Human Services
National Institutes of Health
Office of Equal Opportunity and Diversity Management
Division of Complaints Management and Resolution

PRE-COMPLAINT INTAKE FORM

PERSONAL INFORMATION

_____ Name of the Aggrieved Person	_____ Date of Birth (mm/dd/yyyy)	Gender ☐ Female ☐ Male	XXX-XX-_____ Social Security Number (last 4 digits only)
Home Address: _____ _____			
Home Phone:	Mobile Phone:		

EMPLOYMENT INFORMATION

Position Title, Series and Grade	
Employment Type	☐Permanent--FT ☐Permanent--PT ☐Commissioned Corp ☐Temporary--FT ☐Temporary--PT ☐Contractor/Applicant
Institute/Division/Section	
Work Address: & Phone Number: _____ _____ _____	
Email Address	
Supervisor Name, Title, Institute	
Supervisor Address & Phone Number: _____ _____ _____	

COMPLAINT INFORMATION

Date of contact with OEODM	
Name of OEODM Staff	
What is the <u>date</u> of the most recent incident?	

<u>ANONYMITY:</u> You have the right to remain anonymous at the Pre-Complaint counseling stage.
Do you wish to remain anonymous?

☐ Yes, I elect to remain anonymous
☐ No, I waive my right to remain anonymous

Alleged Bases: Check and specify the basis (es) on which you believe you were discriminated against. If you are alleging age discrimination, give your date of birth.

- To file a complaint based on age, you must be at least 40 years old when the incident occurred.*
- If you are alleging discrimination based on disability, give the nature of your disability. **
- If you are alleging discrimination based on retaliation/reprisal, you must have had prior involvement in the EEO complaint process. ***

Bases: On what basis or bases do you believe you have been discriminated against?

Check	Basis or Bases	Description
	Race	
	Religion	
	Sex	Female ( ) Male ( )
	National Origin	
	Color	
	*Age	DOB:
	**Physical Disability	
	**Mental Disability	
	***Reprisal/Retaliation	
	Sexual Orientation	
	Equal Pay Act	
	Other Basis Not Specified	

CLAIMS: Which claims are you alleging? A claim refers to an assertion of an unlawful employment practice or policy for which, if proven, there is a remedy under the Federal equal employment statutes. Please check all that apply:

	Appointment/Hire		Duty Hours		Reinstatement
	Assignment of Duties		Examination/Test		Retirement
	Awards		Evaluation/Appraisal		Sexual Harassment
	Conversion to Full Time		Harassment (non-sexual)		Termination
	Demotion		Medical Examination		Time & Attendance
	Disciplinary Action-Other		Pay		Training
	Disciplinary Action-Reprimand		Promotion/Non-selection		Terms/Condition of Employment
	Disciplinary Action-Removal		Reassignment-Request Denied		Other Please Specify: _____
	Disciplinary Action-Suspension		Reassignment-Directed		_____

Allegations: **Please provide a brief narrative statement describing incidents in support of the claims(s) listed. Please be sure to list the date of each incident.** *You may attach a separate sheet of paper.*

Alleged Responsible Management Official(s) (RMO)

If applicable, please identify the responsible management official(s) who are alleged to have engaged in the discriminatory act. Please include position title, work address and phone number.

Witness (es)

What are the names of any witness (es) who can support and/or have direct knowledge about your discrimination complaint? Please provide the name and work number of each witness and what you believe s/he knows about the matter at issue. *You may attach a separate sheet of paper.*

Remedy/Resolution

Please describe the terms, conditions, corrective actions, and remedial relief you are seeking in resolving/adjudicating your complaint. *You may attach a separate sheet of paper.*

Selection of EEO Counseling or Alternative Dispute Resolution (ADR)

You must choose between having your precomplaint handled through the traditional counseling procedures or handled through the agency's ADR procedure, if the agency agrees to offer ADR in your particular case. Your election must be made on this form. Your election to proceed through EEO counseling or ADR is final.

I have elected:

☐ **ADR Process** ☐ **EEO counseling**

Designation of Representative: You have the right to retain representation of your choice. The representative can be anyone of your choosing. You may elect to have a representative at any stage in the process. Please complete below if choosing a representative at this time.

Name of Representative _____

Address and Phone Number: _____

_____

Is your representative an attorney? ☐ Yes ☐ No

Is your representative an employee of the Agency? ☐ Yes ☐ No

Other Background Information:
I have previously pursued the claims/issues I am raising from this complaint via:

- □ The EEO Complaint Process
- □ The Negotiated Grievance Process
- □ An appeal to the Merit Systems Protection Board
- □ The Administrative Grievance Process

Are you a bargaining unit employee? (Union) ☐ Yes ☐ No
If previously pursued claims/issues exist, please list the dates and provide information regarding the status of each complaint, grievance, or appeal filed.

Documentation: Please attach any documentation you wish to support your allegation(s). Include a copy of any written actions(s) which caused you to seek counseling at this time.

Attachments:
DHHS Rights and Responsibilities of Aggrieved Person in the EEO Complaint Process

_____ _____

Signature of the Aggrieved Date

NOTE: Please sign, make copy, and return this original form ***within 3 business days to***:

OEODM/DCMR
Attn: Pre-Complaint Intake
2 Center Drive
Bldg. 2, Room 3E24A
MSC 0245
Bethesda, MD 20892
VIA FACSIMILE: 301-402-0994

If you do not hear from a counselor or mediator within 3 business days, please call the OEODM/DCMR at (301) 496-1551.

If you require a **Reasonable Accommodation** (e.g. TTY/TDD, Sign Language Interpreter, etc.) for the counseling process, please DCMR directly at (301) 496-9100 (TTY)

Privacy Act Statement –
[Authority: 42 U.S.C. 2000e-16 et seq and 29 CFR 1614.106.]

Principle Purpose: Informal and formal taking of allegation of discrimination because of race, color, national origin, religion, sex, age, disability or reprisal**.**
Routine Uses: This form and the information on this form may be used: (a) as a data source for complaint information for production of summary descriptive statistics and analytical studies of complaints processing and resolution efforts and may be used to respond to general requests for information under the Freedom of Information Act: (b) to respond to requests from legitimate outside individuals or agencies (e.g. Members of Congress, The White House, the Equal Employment Opportunity Commission, or Federal Courts) regarding the status of the complaint or appeal: and (c) to adjudicate complaint or appeal.
Collection of your social security number, which is solely for identification purposes, is authorized under Executive Order 9397.
Disclosure: Voluntary; however, failure to complete all appropriate portions of this form may lead to rejection of complaint on the basis of inadequate data on which to determine if complaint is acceptable.