VDH VIRGINIA DEPARTMENT OF HEALTH

To protect the health and promote the well-being of all people in Virginia.

Office of the Commissioner
VDH Procedure Number: 01.01.150 F
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Discrimination Complaint Form

If you have questions or need assistance with this form, please contact Claudia Guerrero-Barrera, Non-Discrimination Coordinator at 804-489-7269 (TTY: 1-800-828-1120) or Civil_Rights@vdh.virginia.gov. **Please type or print.** You may also file your complaint via telephone at the number listed above.

Complainant	
*First Name:	First Name
*Last Name:	Last Name
(Please provide either a phone number or email address)	
Phone (Include area code):	Phone
Email Address:	Email
*Street Address Line 1:	Street Address Line 1
*Street Address Line 2:	Street Address Line 2
*City:	City
*State:	State
*ZIP:	ZIP
Are you filing this complaint on behalf of someone else? (If Yes, complete the fields below)	Yes ☐ No ■
Impacted Party First Name:	First Name
Impacted Party Last Name:	Last Name
Complainant Relationship to Impacted Party:	Relationship

Complaint Details	
***I believe that I have been (or the Impacted Party has been) discriminated against on the basis of:**	
☐ Race / Color	☐ National Origin (Including limited English Proficiency)
☐ Age	☐ Religion
☐ Sex	☐ Disability
☐ Other (specify) Click or tap here to enter text.	
Who do you believe discriminated against you?	
Person's First and Last Name or Agency/Organization's Name:	
*Street Address Line 1:	Street Address Line 1
*Street Address Line 2:	Street Address Line 2
*City:	City
*State:	State
*ZIP:	ZIP
Phone (Include area code):	Phone

When do you believe the discrimination occurred? *(If you wish to report more than three dates, list those in the description of the Complaint below)*	
*Violation Date(s):	Click or tap to enter a date.
	Click or tap to enter a date.
	Click or tap to enter a date.

***Describe briefly what happened. How and why do you believe the actions described constitute discrimination? Please be as specific as possible. (Attach additional pages as needed)**
Click or tap here to enter description.

Filing a complaint with VDH is voluntary. VDH will use the information you provide to determine if VDH has jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially. Names or other identifying information about individuals are disclosed only when it is necessary for investigation of possible discrimination and other uses where disclosure is permitted by law.

Signature	
I affirm that the information provided within this Complaint is true and accurate to the best of my knowledge. I authorize the Virginia Department of Health to obtain any records or information necessary for full investigation of my complaint. Click or tap to enter a date.	
Signature of Complainant	Today's Date

Please submit your completed and signed Complaint Form via one of the following:

- Mail: ATTN: Non-Discrimination Coordinator, VDH, 109 Governor St., Richmond, VA 23219
- E-mail: Civil_Rights@VDH.Virginia.gov
- Fax: (804) 864-7022

Good Cause for Late Filing
*If you are filing this Complaint more than 90 days after the alleged discrimination occurred, please indicate why you were unable to file the Complaint timely.
Click or tap here to enter text.