



# CITY OF LODI

221 WEST PINE ST.  
P.O. BOX 3006  
LODI, CALIFORNIA 95241-1910  
(209) 333-6700 / FAX (209) 333-6807  
[www.lodi.gov](http://www.lodi.gov)

## DISCRIMINATION COMPLAINT FORM

Complainant Name: \_\_\_\_\_

Complainant Address: \_\_\_\_\_

Complainant Phone Number: \_\_\_\_\_

Employee: \_\_\_\_\_ Applicant: \_\_\_\_\_ Citizen: \_\_\_\_\_ Vendor: \_\_\_\_\_

When did the discrimination occur? (date): \_\_\_\_\_

Describe the acts of discrimination providing the name(s) where possible of the individuals who discriminated, list witnesses, if any: (attach a separate piece of paper if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your relationship to the person listed above?

- Co-worker    Supervisor    Manager    Department Head    Unknown  
 Other \_\_\_\_\_

I allege Discrimination based on the following category:

- Age    Gender expression    National origin    Religion  
 Ancestry    Gender identity    Physical or mental disability    Sex  
 Color    Genetic information    Political affiliation or belief    Sexual orientation  
 Creed    Marital status    Pregnancy  
 Gender    Medical condition    Race

What remedy are you seeking to resolve the matter?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that this information is correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Complainant

\_\_\_\_\_  
Date signed

Return the completed form to the attention of the ADA Chief Compliance Officer, c/o Office of the City Manager at the address listed at the top of the form.