NAME ________________________________________________________________
STREET ADDRESS ____________________________________________________________________________
CITY, STATE, ZIP CODE _________________________________________________________________________
PHONE _______________________________________________________________________________________
NAME, POSITION AND DEPARTMENT OF PERSON WHO DISCRIMINATED AGAINST YOU:
NAME ________________________________________________________________
POSITION/DEPARTMENT _____________________________________________________________

PLEASE IDENTIFY ANY WITNESSES TO THE DISCRIMINATION AND PROVIDE CONTACT INFO:

WITNESS          NAME ______________________________          PHONE ______________________________
WITNESS          NAME ______________________________          PHONE ______________________________
WITNESS          NAME ______________________________          PHONE ______________________________

DATE(S) OF DISCRIMINATION COMPLAINED OF _______________________________________________________

I WAS DISCRIMINATED AGAINST BECAUSE OF (CHECK ONE):

___ RACE       ___ COLOR       ___ NATIONAL ORIGIN      ___ DISABILITY

Pickens County is an equal opportunity provider and employer.
PLEASE EXPLAIN WHAT HAPPENED DESCRIBING HOW YOU WERE DISCRIMINATED AGAINST AND WHO WAS INVOLVED. BE SURE TO INCLUDE HOW OTHER PERSONS WERE TREATED DIFFERENTLY THAN YOU. ATTACH ANY WRITTEN MATERIAL YOU MAY HAVE THAT SUPPORTS YOUR CLAIM TO DISCRIMINATION.

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PLEASE RETURN THIS FORM TO:

PICKENS COUNTY GOVERNMENT
TITLE VI COORDINATOR
HUMAN RESOURCES DEPARTMENT
222 MCDANIEL AVE B-14
PICKENS, SC 29671

SIGNATURE ________________________________ DATE __________