

STATE OF CALIFORNIA
 DEPARTMENT OF FORESTRY AND FIRE PROTECTION
INTERNAL EMPLOYMENT DISCRIMINATION COMPLAINT FORM
 AA-8 (Rev. 3/05) Page 1 of 2

NAME OF COMPLAINANT		CURRENT JOB CLASSIFICATION
WORK ADDRESS		REGION/UNIT/PROGRAM/DIVISION
HOME MAILING ADDRESS		WORK TELEPHONE (INCLUDE AREA CODE)
CITY	ZIP CODE	HOME TELEPHONE
		CONFIDENTIAL E-MAIL ADDRESS

1. Specify the basis of the complaint: (check appropriate box[es]):

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Race | <input type="checkbox"/> National Origin | <input type="checkbox"/> Medical Condition | <input type="checkbox"/> Sex (Gender) | <input type="checkbox"/> Sexual Identity |
| <input type="checkbox"/> Color | <input type="checkbox"/> Ancestry | <input type="checkbox"/> Religion | <input type="checkbox"/> Sexual Harassment | <input type="checkbox"/> Marital Status |
| <input type="checkbox"/> Age | <input type="checkbox"/> Disability | <input type="checkbox"/> Retaliation | <input type="checkbox"/> Sexual Orientation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Family Medical Leave Act/California Family Rights Act | | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Veteran Status | |

2. Specify issue/method of the discrimination: (check appropriate box[es]):

- | | | |
|---|---|---|
| <input type="checkbox"/> Selection | <input type="checkbox"/> Treatment | <input type="checkbox"/> Working Conditions |
| <input type="checkbox"/> Promotion | <input type="checkbox"/> Demotion or Disciplinary Action | <input type="checkbox"/> Training issues |
| <input type="checkbox"/> Termination | <input type="checkbox"/> Leave: Sick, Vacation, Maternity, and Family Medical | |
| <input type="checkbox"/> Other
(specify) | | |

3. State the name(s) of the employee(s) charged with discrimination:

4. Briefly describe the actions which you believe are discriminatory: (include what, where, when, who)

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5. If this Complaint was discussed with an EEO Counselor, indicate:

Name _____	Location _____
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6. Specify any actions taken to informally resolve the complaint:

7. State names, titles, and telephone numbers of any witnesses: *(Indicate if corroborating/hostile witnesses)*

8. Specify the remedy requested by you:

9. Give a brief description of your employment with CDF: (positions held, dates, locations)

To initiate a formal complaint of discrimination within CDF, submit this form, with the unit Equal Employment Opportunity Counselor, the Regional Equal Employment Opportunity Manager or the Equal Employment Opportunity Officer within one year of the date of the incident.

Additional information regarding the filing of discrimination complaints can be found in the CDF Personnel Procedures Manual Section 1400 or by contacting the CDF Regional Equal Employment Opportunity Manager or CDF's Equal Employment Opportunity Officer.

Retaliation against an employee filing a complaint is illegal and will not be tolerated. Contact the CDF Regional Equal Employment Opportunity Manager or CDF's Equal Employment Opportunity Officer immediately if you believe you are being retaliated against for filing a complaint.

Signature of Complainant

Date Filed

Received by

Date Received