



# City of Portsmouth Human Rights Commission Fair Employment and Housing Intake Form

The Human Rights Commission is administered by the City of Portsmouth, Office of Community Development located at 728 Second Street Portsmouth, Ohio 45662. If you need assistance filling out this form call (740) 354-5673 or email [tshearer@porstmouthoh.org](mailto:tshearer@porstmouthoh.org).

Complainant Name:

Telephone Number:

Address

Email Address:

Do you need an interpreter during the complaint process Yes\_\_\_ No\_\_\_  
If yes, indicate language\_\_\_\_\_

Respondent Name:

Telephone Number:

Address

Email Address

Number of employees \_\_\_\_\_

Add Co-Respondent:

Name:

Title:

Address:

Telephone Number:

Dates of Harm:

First Date of Harm (Month/Day/Year):

Last Date of Harm (Month/Day/Year):



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1.) I ALLEGE THAT I EXPERIENCED:  Discrimination  Harassment

### BECAUSE OF MY ACTUAL OR PERCEIVED:

- AGE (40 and over)
- ANCESTRY
- ASSOCIATION WITH A MEMBER OF A PROTECTED CLASS
- COLOR
- DISABILITY (physical or mental)
- FAMILY CARE OR MEDICAL LEAVE (CFRA) (employers of 5 or more people) includes pregnancy, childbirth, breastfeeding, and/or related medical conditions; baby bonding; care for self or child, parent, grandparent, sibling, spouse, or domestic partner.
- GENDER IDENTITY OR EXPRESSION
- GENETIC INFORMATION OR CHARACTERISTIC
- MARITAL STATUS
- MEDICAL CONDITION (cancer or genetic characteristic)
- MILITARY AND VETERAN STATUS
- NATIONAL ORIGIN (includes language restrictions)
- RACE
- RELIGIOUS CREED
- SEX/GENDER
- SEXUAL HARASSMENT – hostile environment
- SEXUAL HARASSMENT – quid pro quo
- SEXUAL ORIENTATION
- OTHER (specify)



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### AS A RESULT, I WAS:

- Asked impermissible non-job-related questions
- Demoted
- Denied accommodation for pregnancy
- Denied accommodation for religious beliefs
- Denied any employment benefit or privilege
- Denied employer paid health care while on pregnancy disability leave
- Denied equal pay (includes violations of the Equal Pay Act)
- Denied Family Care or Medical Leave (CFRA) (employers of 5 or more people) includes pregnancy, childbirth, breastfeeding, and/or related medical conditions; baby bonding; care for self or child, parent, grandparent, sibling, spouse, or domestic partner.
- Denied Hire or promotion
- Denied or forced to transfer
- Denied reasonable accommodations for a disability
- Denied the right to wear pants
- Denied work opportunities or assignments
- Forced to quit
- Laid off
- Reprimanded
- Suspended
- Terminated
- Other (specify)



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I ALLEGE THAT I EXPERIENCED:  Retaliation

### BECAUSE I:

- Participated as a witness in a discrimination or harassment complaint
- Reported or resisted any form of discrimination or harassment
- Reported patient abuse (hospital employees only)
- Requested or used a disability-related accommodation
- Requested or used a religious accommodation
- Requested or used Family Care or Medical Leave (CFRA) (employers of 5 or more people) includes pregnancy, childbirth, breastfeeding, and/or related medical conditions; baby bonding; care for self or child, parent, grandparent, sibling, spouse, or domestic partner.

### AS A RESULT, I WAS:

- Asked impermissible non-job-related questions
- Demoted
- Denied accommodation for pregnancy
- Denied accommodation for my religion
- Denied any employment benefit or privilege
- Denied employer paid health care while on pregnancy disability leave
- Denied equal pay (includes violations of the Equal Pay Act)
- Denied Family Care or Medical Leave (CFRA) (employers of 5 or more people) includes Pregnancy, childbirth, breastfeeding, and/or related medical conditions; baby bonding; care for self or child, parent, grandparent, sibling, spouse, or domestic partner.
- Denied hire or promotion
- Denied or forced to transfer
- Denied reasonable accommodation for a disability
- Denied the right to wear pants
- Denied work opportunities or assignments



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- Forced to quit
- Laid off
- Reprimanded
- Suspended
- Terminated
- Other (specify) \_\_\_\_\_

2. Do you have an attorney who agreed to represent you in this matter?  Yes  No

If yes, please provide the attorney's contact information.

### COMPLAINANT'S REPRESENTATIVE INFORMATION

Attorney Name: \_\_\_\_\_

Attorney Firm Name: \_\_\_\_\_

Attorney Address: \_\_\_\_\_

Attorney City, State, and Zip: \_\_\_\_\_

Briefly describe what you believe to be the reason(s) for the discrimination, harassment, or retaliation. (Optional)

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## DEMOGRAPHIC INFORMATION

THIS INFORMATION IS OPTIONAL AND IS ONLY USED FOR STATISTICAL PURPOSES.

Primary Language: \_\_\_\_\_ D.O.B. \_\_\_\_\_

### GENDER/GENDER IDENTITY:

- MALE     FEMALE     NON-BINARY     OTHER

### MARITAL STATUS:

- SINGLE     MARRIED     COHABITATION     DIVORCE

### RACE:

- AMERICAN INDIAN, NATIVE AMERICAN OR ALASKAN NATIVE     NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER  
 ASIAN     WHITE  
 BLACK OR AFRICAN AMERICAN     OTHER

### ETHNICITY:

- HISPANIC OR LATINO     NON-HISPANIC OR LATINO

### NATIONAL ORIGIN:

- AFGHANI     GERMAN     JAPANESE     OTHER MIDDLE EASTERN  
 AMERICAN     GHANAIAN     KOREAN     PAKISTANI  
 ASIAN INDIAN     GUAMANIAN     LAOTIAN     PUERTO RICAN  
 BANGLADESHI     HAITIAN     LEBANESE     SALVADORAN  
 CAMBODIAN     HAWAIIAN     MALAYSIAN     SAMOAN  
 CANADIAN     HMONG     MEXICAN     SRI LANKAN  
 CHINESE     INDONESIAN     NIGERIAN     SYRIAN  
 CUBAN     IRANIAN     OTHER     TAIWANESE  
 DOMINICAN     IRAQI     OTHER AFRICAN     THAI  
 EGYPTIAN     IRISH     OTHER ASIAN     TONGAN  
 ENGLISH     ISRAELI     OTHER CARIBBEAN  
 ETHIOPIAN     ITALIAN     OTHER EUROPEAN  
 FILIPINO     JAMAICAN     OTHER HISPANIC/LATINO



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## DEMOGRAPHIC INFORMATION

THIS INFORMATION IS OPTIONAL AND IS ONLY USED FOR STATISTICAL PURPOSES.

### DISABILITY:

- |   |   |
|---|---|
| <input type="checkbox"/> AIDS or HIV                    | <input type="checkbox"/> LIMBS (ARMS/LEGS)  |
| <input type="checkbox"/> BLOOD CIRCULATION              | <input type="checkbox"/> MENTAL             |
| <input type="checkbox"/> BRAIN/NERVES/MUSCLES           | <input type="checkbox"/> SIGHT              |
| <input type="checkbox"/> DIGESTIVE/URINARY/REPRODUCTION | <input type="checkbox"/> SPEECH/RESPIRATION |
| <input type="checkbox"/> HEARING                        | <input type="checkbox"/> SPINAL/BACK        |
| <input type="checkbox"/> HEART                          | <input type="checkbox"/> OTHER DISABILITY   |

### RELIGION:

- |  |   |
|--|---|
| <input type="checkbox"/> AGNOSTIC          | <input type="checkbox"/> NONRELIGIOUS           |
| <input type="checkbox"/> ATHEIST           | <input type="checkbox"/> PROTESTANTISM          |
| <input type="checkbox"/> BAHAI             | <input type="checkbox"/> PRIMAL-INDIGENOUS      |
| <input type="checkbox"/> BUDDHISM          | <input type="checkbox"/> QUAKERS                |
| <input type="checkbox"/> CATHOLICISM       | <input type="checkbox"/> RASTAFARIANISM         |
| <input type="checkbox"/> CHRISTIANITY      | <input type="checkbox"/> SPIRITISM              |
| <input type="checkbox"/> CONFUCIANISM      | <input type="checkbox"/> SHINTO                 |
| <input type="checkbox"/> HINDUISM          | <input type="checkbox"/> SIKHISM                |
| <input type="checkbox"/> ISLAM             | <input type="checkbox"/> TAOISM                 |
| <input type="checkbox"/> JEHOVAH'S WITNESS | <input type="checkbox"/> UNITARIAN-UNIVERSALISM |
| <input type="checkbox"/> JUDAISM           | <input type="checkbox"/> ZOROASTRIANISM         |
| <input type="checkbox"/> NEO-PAGANIS       | <input type="checkbox"/> OTHER                  |

### SEXUAL ORIENTATION:

- STRAIGHT OR HETEROSEXUAL    GAY OR LESBIAN    BISEXUAL    OTHER