



PHILADELPHIA COMMISSION ON HUMAN RELATIONS

EMPLOYMENT DISCRIMINATION INTAKE FORM

INSTRUCTIONS

This packet contains the form you will need to complete to begin the process of filing a discrimination complaint with the Philadelphia Commission on Human Relations (PCHR). You can also download and print this form from our website: www.phila.gov/humanrelations. The form asks for some of the basic information that we need to decide whether or not we can investigate your employment problem. If you have difficulty understanding these instructions or have questions, our staff can assist you.

The **Employment Discrimination Intake Form** asks questions about why you believe you were treated unfairly and how you believe this treatment was against the law. In Philadelphia, the law protects employees against unfair treatment in employment on the basis of:

- | | |
|--|-------------------------------------|
| ✓ Age (40 or over) | ✓ Protective or Cultural Hairstyles |
| ✓ Ancestry | ✓ Genetic Information |
| ✓ Breastfeeding | ✓ Marital Status |
| ✓ Color | ✓ National Origin |
| ✓ Conviction History | ✓ Race |
| ✓ Credit Information | ✓ Religion |
| ✓ Disability | ✓ Retaliation |
| ✓ Ethnicity | ✓ Sex |
| ✓ Pregnancy/Childbirth or Related Medical Condition | ✓ Sexual Orientation |
| ✓ Familial Status | ✓ Sex Stereotyping |
| ✓ Gender Identity | ✓ Wage History |
| ✓ Victim of Domestic Violence Sexual Assault or Stalking | |

The PCHR Cannot Investigate Employment Complaints Based on General Mistreatment

There are many reasons people are treated unfairly, and several of these reasons may not be against the law. The PCHR can only investigate employment complaints based on illegal mistreatment relating to the factors identified above. By law, the PCHR cannot handle general employment concerns based on any other factors. In addition, your complaint should relate to mistreatment that affected you personally. You cannot file a complaint about the treatment of someone else unless you have the legal right to represent that person (e.g., because you are the person's parent or guardian).

Complete the attached form only if you believe you have been discriminated against because of one of the bases listed above. Please take the time to answer all questions completely and accurately.

Special Instructions during the Covid-19 Pandemic:

Our office is currently closed to the public because of the pandemic. However, PCHR is still accepting and investigating complaints of discrimination. Once you have completed this Intake Form, please submit it to our office by U.S Mail, Email or Fax.

Mailing address: Philadelphia Commission on Human Relations

The Curtis Center
601 Walnut Street, Suite 300 South
Philadelphia, PA 19106

Email address: pchr@phila.gov

Fax: 215-686 4684

If after reviewing this form you still have questions, please leave a message on the general number.
A member of our staff will get back to you.

General Phone Number: 215-686-4670

TTY: 215-686-3238

Important:

Submitting the enclosed form does not mean you have filed a discrimination complaint. Once we receive your Intake Form a PCHR staff person will review your form then contact you to let you know whether we can assist you. Preparing and filing a discrimination complaint is a complex matter. Please plan for the intake process to take at least 2 hours.

SPECIAL INSTRUCTIONS IF THE DISCRIMINATION OCCURRED MORE THAN 300 DAYS AGO:

The Philadelphia Commission on Human Relations can only investigate discrimination that occurred within the past 300 days. If your complaint involves events that occurred more than 300 days, please contact our office immediately. If you fail to complete all of the steps for filing a complaint within the legal time period, our staff will not be able to investigate your complaint.



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COMPLAINTS MUST MEET CERTAIN REQUIREMENTS. Please check the boxes to confirm that your claim meets the necessary criteria:

- ☐ Discrimination occurred in the city of Philadelphia.
- ☐ Discrimination occurred within the past 300 days.
- ☐ I **have not** already filed a complaint with the Pennsylvania Human Relations Commission or the EEOC with regard to the same discriminatory acts I will describe in this Intake Form.



If your complaint does not meet the above requirements, PCHR may not be able to investigate it. If you have questions, you may speak with an Intake Representative at 215-686-4670, TTY 216-686-3238.

Some of your answers may require more space than provided here. Please attach additional pages if necessary.

1. PERSONAL INFORMATION

Legal Last Name:	Legal First Name:	Middle Initial:
Preferred Last Name:	Preferred First Name:	Middle Initial:
Preferred Pronoun(s):		
Date of Birth:	Cell Phone:	Home Phone:
Email Address (if available):	Work Phone:	
Street Address (Include Apartment or Unit #):		
City, State, Zip Code:		

2. FILING ON BEHALF OF ANOTHER PERSON ☐ Yes ☐ No

If yes, what is the name of the person who experienced discrimination?

First Name:	Last Name:
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Relationship to You:

Please attach documentation establishing your authority to file on behalf of person named above.

3. BUSINESS, EMPLOYMENT AGENCY OR LABOR ORGANIZATION YOU BELIEVE DISCRIMINATED AGAINST YOU

Name of Business (Employer or Employment Agency) or Labor Organization:

Street Address:

City, State, Zip:

Phone:

Website:

Job Location (if different from above address)

Street Address:	
City, State, Zip:	Phone:
Website:	
Name of Owner, Supervisor or Manager:	Owner, Supervisor, or Manager Phone Number and Email Address:
Total Number of Employees in All Offices Combined:	

Were you placed here by an employment/staffing agency? ☐ Yes ☐ No

If **yes**, please enter the name of the agency?

Street Address:	
City, State, Zip:	Phone:
Website:	
Name of Owner, Supervisor or Manager:	Owner, Supervisor, or Manager Phone & Email Address:

4. EMPLOYMENT HISTORY

Describe your employment history with the organization you believe discriminated against you.

Date(s) Applied:	Position(s) Applied for:
Date Hired:	Hired by (Name & Title):
Job Title when Hired:	Supervisor (Name & Title):
Job Title at Time of Alleged Discrimination:	Supervisor (Name & Title):
Are you currently employed with the organization you are filing against? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Discharged:	If discharged, what is the name and position of the person who discharged you?
Date Resigned:	

5. BASIS OF DISCRIMINATION (Protected Category)

I believe I was discriminated against because of my _____. Please check all that apply. For each category, please state how you identify yourself, where necessary. *For example*, if you checked religion, please specify your religion (such as Catholic, Islam, Jewish, Protestant, Seventh Day Adventist, Sikh). For additional information see website

<https://www.phila.gov/services/diversity-inclusion-accessibility-immigration/discrimination/>

☐ Age 40 or over _____
☐ Ancestry _____
☐ Breastfeeding _____

☐ Color (Difference in skin shade within same race) _____
☐ Conviction History (See also Fair Chance Hiring Intake Form) _____

- | | |
|--|---|
| <input type="checkbox"/> Credit Information _____ | <input type="checkbox"/> Wage History _____ |
| <input type="checkbox"/> Disability (or Perceived Disability) _____ | <input type="checkbox"/> Race _____ |
| <input type="checkbox"/> Victim of Domestic Violence, Sexual Assault or Stalking _____ | <input type="checkbox"/> Religion _____ |
| <input type="checkbox"/> Ethnicity _____ | <input type="checkbox"/> Sex/Gender _____ |
| <input type="checkbox"/> Familial Status _____ | <input type="checkbox"/> Sexual Orientation _____ |
| <input type="checkbox"/> Gender Identity _____ | <input type="checkbox"/> Sex Stereotyping _____ |
| <input type="checkbox"/> Protective or Cultural Hairstyles _____ | <input type="checkbox"/> Retaliation for Prior Discrimination Complaint or Engaging in a Protected Activity _____ |
| <input type="checkbox"/> Genetic Information _____ | <input type="checkbox"/> Pregnancy/ Childbirth/ Related Medical Condition _____ |
| <input type="checkbox"/> Marital Status _____ | |
| <input type="checkbox"/> National Origin _____ | |
| Other (Explain) _____ | |

6. DISCRIMINATORY ACTION TAKEN AGAINST YOU

How were you harmed? Please check the box next to the discriminatory action taken against you then describe the harm in further detail in the space provided in number 7. Please note this is not a complete list of possible discriminatory actions. If the harm you experienced is not on this list, check the box marked *other*, identify the harm in a few words then describe it in further detail in number 7. Add additional pages if necessary.

- | | |
|---|---|
| <input type="checkbox"/> Adverse Action Based on Credit History | <input checked="" type="checkbox"/> Forced to Quit |
| <input type="checkbox"/> Demotion_ | <input checked="" type="checkbox"/> Forced Transfer |
| <input type="checkbox"/> Denied Leave | <input type="checkbox"/> Harassment/ Sexual Harassment |
| <input type="checkbox"/> Denied Transfer | <input type="checkbox"/> Reliance on Wage History to Set Compensation |
| <input type="checkbox"/> Discharge /Termination_ | <input type="checkbox"/> Job Offer Withdrawn_ |
| <input type="checkbox"/> Discipline (Suspension, warning, etc.) | <input type="checkbox"/> Protected category Considered When Making Job Referral |
| <input type="checkbox"/> English Language Only Rule/ Other Language /Accent Issues | <input type="checkbox"/> Labor Organization Adversely Affects Employee Status/ Wages or Employment Opportunity |
| <input type="checkbox"/> Exclude from Apprenticeship | <input type="checkbox"/> Layoff |
| <input type="checkbox"/> Exclude from Training | <input type="checkbox"/> Quota System |
| <input type="checkbox"/> Exclusionary Advertising | <input type="checkbox"/> Pre-employment Inquiry Beyond Relevant Qualifications includes questions about disability, race, age or any other protected category that are unrelated to the job; or test unrelated to job. <i>For Inquiry about Conviction History See Fair Chance Hiring Intake Form</i> |
| <input type="checkbox"/> Fail to Accommodate Because of Disability | <input type="checkbox"/> Threaten Intimidate Coerce |
| <input type="checkbox"/> Fail to Accommodate Because of Pregnancy | <input type="checkbox"/> Unequal Terms & Conditions of Employment including but not limited to Granting Breaks/Approving Leave/ Designation to Less Desirable Assignment, Shift or Location |
| <input type="checkbox"/> Fail to Accommodate Because of Religion | <input type="checkbox"/> Unequal Benefits |
| <input type="checkbox"/> Fail to Accommodate Need to Express Breast Milk or Breastfeed_ | <input type="checkbox"/> Unequal Wages |
| <input type="checkbox"/> Fail to Permit Leave Because of Domestic Violence Stalking or Sexual Assault | <input type="checkbox"/> Other |
| <input type="checkbox"/> Failure to Hire_ | |
| <input type="checkbox"/> Failure to Promote_ | |
| <input type="checkbox"/> Failure to Recall after Layoff | |
| <input type="checkbox"/> Failure to, Upon Request, Change Name or Gender | |
| <input type="checkbox"/> False Reference or Refuse to give Reference | |
| <input type="checkbox"/> Forced Leave | |

7. Please describe the actions or events that you believe were discriminatory. Be specific and include date, action and name of person responsible. Add additional pages if necessary.

Date	Discriminatory Action (<i>For example: I was suspended</i>)	Name and Title of Person Responsible

9. Why do you believe these actions were discriminatory?

10. What reasons, if any, were you given for the actions taken against you? Who said it and what is their job title?

11. Do you believe the reason(s) given to you were false? Why?

12. EMPLOYEES IN SIMILAR SITUATIONS (SAME OR SIMILAR JOB, SAME OR SIMILAR RESPONSIBILITIES)

Describe employees who were treated better than you. *For example, male supermarket cashiers given 15-minute breaks, female supermarket cashiers are given 10-minute breaks.*

Full Name	Job Title	Description of Treatment (Please provide details)

REASONABLE ACCOMMODATION (DISABILITY)

Answer Questions 13-15 only if you are claiming discrimination based on disability. If not, skip to Question 16. Please state if you have more than one disability.

Please check all that apply:

- ☐ Yes, I have a disability.
☐ I do not have a disability now, but I did have one.
☐ I do not have a disability, but my employer treats me as if I do. What disability does your employer think you have? — — — — —

13. What is the disability that you believe is the reason for the adverse action taken against you? Does this disability substantially limit one or more major life activities, such as walking, bending, lifting, speaking, hearing, seeing, concentrating or communicating? If so, how does this disability affect you?

14. Do you use medication, medical equipment to reduce or eliminate the effects of your disability in your daily life? For example: Use a wheelchair to aid with mobility, wear noise cancelling headphones to reduce sensitivity to specific sounds or administer insulin for diabetes.

☐ Yes ☐ No

a. If yes, what equipment, medications or other measures do you use?

15. Did you ask your employer for any changes or assistance to do your job because of your disability?

☐ Yes ☐ No

a. If yes, please state when you asked, how you asked, who you asked, what changes or assistance you requested and how the employer responded to your request.

Date	Verbal or Written Request?	Name and Title of Person(s) Asked	Changes or Assistance Requested	Employer Response

REASONABLE ACCOMMODATION (RELIGION)

Answer Questions 16-18 if you are claiming discrimination based on religion. If not, skip to Question 19.

16. Did you ask your employer for any changes to your job because of your religion?

☐ Yes

☐ No

17. What is your religion? _____

18. If you answered yes to # 16 please state when you asked, how you asked, who you asked, what changes or you requested and how the employer responded to your request. Add additional pages if necessary

Date	Verbal or Written Request?	Name and Title of Person(s) Asked	Changes or Assistance Requested	Employer Response

19. WITNESSES TO DISCRIMINATION

Are there any witnesses to the alleged discriminatory incidents?

☐ Yes

☐ No

a. If yes, please identify them below and describe what you believe they will say.

Full Name	Job Title	Address & Phone Number	What You Believe This Person Will Say

20. Are there any documents or electronic records about the alleged discriminatory incidents?

☐ Yes

☐ No

a. If yes, please identify below and indicate where / from whom we might obtain them.

Document or other Type of Record	Where / From Whom We Can Obtain Record

21. LEGAL REPRESENTATION

Are you represented by a lawyer?

☐ Yes

☐ No

a. If yes, please provide your lawyer's name and contact information.

Lawyer's Name and/or Name of Law Office or Legal Organization	Phone Number / email address	Email Address	

22. ALTERNATE CONTACT INFORMATION

If we cannot reach you directly, is there someone we can contact to help us reach you?

First Name:	Last Name:
Cell Phone:	Home Phone:
Street Address (Include Apartment or Unit #):	
City, State, Zip Code:	Email Address (if available):
Relationship to You:	

23. Please check one of the boxes below to tell us what you would like us to do with the information you are providing on this questionnaire. If you would like to file a discrimination complaint, you must do so within 300 days from the day you knew about the discrimination. If you do not file a complaint within the time limits, you will lose your rights. If you would like more information before filing a complaint or you have concerns about PCHR's notifying the organization about your complaint, you may wish to check Box 1. If you want to file a complaint, check Box 2.

BOX 1 ☐ I want to talk to a PCHR employee before deciding whether to file a complaint. I understand that by checking this box, I have not filed a complaint with the PCHR. **I also understand that I could lose my rights if I do not file a complaint in time.**

BOX 2 ☐ I want to file a complaint of discrimination, and I authorize the PCHR to look into the discrimination I described above. I understand that **the PCHR must give the employer, union, or employment agency that I accuse of discrimination information about the complaint, including my name.** I also understand that the PCHR can only accept complaints of employment discrimination based on age, ancestry, breastfeeding, color, conviction history, credit information, disability, domestic or sexual violence, ethnicity, familial status, gender identity, genetic information, marital status, national origin, pregnancy, protective or cultural hair styles, race, religion, retaliation, sex, sexual orientation, sex stereotyping or wage history.

24. If you checked Box 2 above, what would you like to have happen in response to your complaint? (Ex. job restored, back pay, seniority reinstated, guarantee of no future discrimination, work record cleansed)

I declare under penalty of perjury that all of the information that I have provided on this form is true, correct, and complete to the best of my knowledge. I acknowledge that false statements on this form are punishable under state law, 18 Pa. C.S. § 4904 (unsworn falsification to authorities).

Signature

Today's Date