

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

**DEPARTMENT OF HEALTH
DISCRIMINATION COMPLAINT FORM**
(Title VII, Title VI and Section 504 of the Rehabilitation Act)

DOH # _____
(Equal Opportunity Section Only)

Date: _____

Employee _____

Client, Patient, or Beneficiary _____
(Program Services or Activities)

Applicant _____
(Employment)

Complainant Information:

Name (Type or Print) Employee ID# (if applicable) *Date of Birth (Month, Year)

Street Address City State and Zip Code

Telephone Numbers: (include area code) Home Work (ext.) Cell/Other

List Name(s) of the Person(s) Discriminating Against You:

Name (Type or Print) Program/Facility/Division

Street Address City, State and Zip Code

Check Basis of Discrimination: I believe that I have been discriminated against because of (check all that apply):

_____ Race _____ Color _____ Sex-Female _____ Sex-Male _____ Disability
_____ Religion _____ Age* _____ National Origin _____ Marital Status _____ Retaliation
_____ Genetic Information _____ Sexual Harassment _____ Other

Date of Most Recent or Continuing Discrimination Took Place (Month, Day, Year)

Department of Health
Discrimination Complaint Form con't.

Give Full Details of Complaint: (Use additional sheet(s) if necessary)

Discrimination Statement: (Provide facts, details, dates and comparative statements, i.e., how others of a different race or sex, etc., were treated differently or more favorably.)

Reason for Adverse Action: (State reason given for action taken and Name/Title of person(s) involved.)

Personal Harm: (State what harm occurred to you)

I declare that the foregoing is true and correct to the best of my knowledge and information.

Signature of Complainant

Date:

Applicants and Employees who believe they have been discriminated against may file a complaint with the **Office of the General Counsel, Equal Opportunity Section, 4052 Bald Cypress Way, Bin #A02, Tallahassee, FL 32399-1701** within **365 days** of the alleged discriminatory action. **DOH Clients, Beneficiaries, and/or Applicants for benefits** may file a complaint within **180 days** of the alleged discrimination. For more information on how to file a complaint against the Department, call (850) 245-4002, or TDD (850) 410-1451, or Florida Relay Service 711. Or you may **e-mail** the manager of the Equal Opportunity Section, **eo@doh.state.fl.us**