



Florida Commission on Human Relations

Technical Assistance Questionnaire for Public Accommodation Complaints

Your answers to this questionnaire are confidential pursuant to Florida Statute 760.11(12).

The primary purpose of this questionnaire is to solicit information about claims of discrimination, determine whether the Florida Commission on Human Relations (FCHR) has jurisdiction over those claims and provide charge filing counseling, as appropriate. Providing this information is voluntary, but the failure to do so may impede the Commission's investigation of a charge. It is not mandatory that this form be used to provide the requested information. NOTE: The FCHR may disclose the information included on this form to other state, local and federal agencies as appropriate or necessary to carry out the Commission's functions, or if the FCHR becomes aware of a civil or criminal law violation. If the FCHR accepts this form as a charge, this form will be provided to the organization identified.

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Please complete this entire form (please print) and return it to the Commission at the address listed at the bottom of this form. Answer all questions completely. Attach additional pages if needed to complete your responses. If you do not know the answer to a question, answer by stating "not known." If a question is not applicable, write "N/A."

REMEMBER, a charge of public accommodation discrimination must be filed within 365 days of the alleged act of discrimination.

1. Personal Information

Last Name: _____ First Name: _____ MI: _____

Street or Mailing Address: _____ Apt or Unit #: _____

City: _____ County: _____ State: _____ Zip: _____

Phone Numbers: Home: (_____) _____ Work: (_____) _____

Mobile telephone: (_____) _____ Email address: _____

Date of Birth: _____

Sex: Male Female

2. Please provide the name of a person we can contact if we are unable to reach you:

Name: Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Other Phone: (____) _____

3. I believe that I was discriminated against by the following organization(s):

Organization Name: _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Type of Business: _____

Owner Name: _____ Phone: (____) _____

4. Organization Representative Contact Information (If known):

Representative Name: _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Phone Numbers: Home: (____) _____ Work: (____) _____

Mobile telephone: (____) _____ Email address: _____

5. What is the reason (basis) for your claim of public accommodations discrimination? Check all that apply.

FOR EXAMPLE, if you feel that you were treated worse than someone else because of race, you should check the box next to race. If you feel you were treated worse for several reasons, such as your sex, religion and national origin, check all of these bases.

Race: Black White Asian Native Hawaiian/Pacific Islander American Indian or Alaska Native

Color: Light Skinned Dark Skinned Other: _____

National Origin: Hispanic Mexican Arab/Afghani/Middle Eastern East Indian Other: _____

Sex: Female Male

Pregnant or condition related to pregnancy or childbirth

Religion (Please identify): _____

Disability/Handicap: Physical Mental

Familial Status (Please identify): _____

Other Reason (basis) for Discrimination (describe): _____

6. What happened to you that you believe was discriminatory? Include the date(s) of harm, the action(s), and the name(s) and title(s) of the person(s) who you believe discriminated against you. Please attach additional pages if needed. *(Example: 08/08/2011 – Refused service by Mr. John Smith, waiter)*
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Answer question 7 only if you are claiming discrimination based on disability. If not, skip to question 8.

7. Do you have a disability, which is a physical or mental impairment that substantially limits a major life activity, such as caring for yourself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working? Please check all that apply:

- Yes, I have a disability.
- I do not have a disability now but I did have one.
- No disability, but the organization treats me as if I am disabled.

8. Have you filed this charge previously with another agency? Yes No

If so, provide the name of the agency and the date of filing: _____

9. Have you sought help about this situation from a union, an attorney, or any other source? Yes No

If so, provide the name of organization, name of person you spoke with, date of contact and the results or outcome, if any.

10. How did you learn about the services provided by the Florida Commission on Human Relations?

- Commission website
- Other website (Please identify): _____
- Poster/kiosk/billboard
- Friend/family member
- Attorney
- Landlord/realtor/bank
- Already familiar with
- Legislator, city/county council person
- Other (Please identify): _____

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 charge of public accommodations discrimination, you must do so within 365 days from the date you were allegedly discriminated against. **If you do not file a charge of discrimination within the time limit, you will lose your ability to file a charge. If you would like more information before filing a charge or you have concerns about the FCHR notifying the organization about your charge, you may wish to check Box 1. If you want to file a charge, you should check Box 2.**

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

BOX 2 I want to file a charge of discrimination, and I authorize the FCHR to look into the discrimination I described above. I understand that **the FCHR must give the organization that I accuse of discrimination information about the charge, including my name.** I also understand that the FCHR can only accept charges of discrimination based on race, religion, sex, pregnancy, national origin, disability, age, genetic information, or retaliation for opposing discrimination. **By signing below, I verify that I have read the above information and that the facts stated are true.**

NOTE: If you have checked Box 2 above, and your case is already 350 days or more from the alleged discrimination, the FCHR will accept this form as a charge if it meets the elements of a charge.

Signature: _____ Date: _____

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Facsimile (850) 487-1007