COMPLAINT FORM

Name: ____________________________________________________________________

Address: __________________________________________________________________

City: ________________________________State: _____________ Zip Code: ___________

Home Telephone No: (_____) ______________________________

Work Telephone No: (_____) _______________________________

Were you discriminated against because of?

[ ] Race [ ] National Origin

[ ] Color

[ ] Other _______________________________________________

Date of Alleged Incident: __________________________________

Explain as clearly as possible what happened and how you were discriminated against. Indicate who was involved. Be sure to the names and contact information of any witnesses. If more space is needed please use the back of form.

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Have you filed this complaint with any other federal, state, or local agency; or with any federal or state court? ________Yes ________No

If yes, check all that apply:

_____Federal agency _____Federal court _____State agency _____State court

_____Local agency
COMPLAINT FORM

Please provide information about a contact person at the agency/court where the complaint was filed.

Name: ____________________________________________________

Address: __________________________________________________

City, State, and Zip Code: ______________________________________

Telephone Number: __________________________________________

Please sign below. You may attach any written materials or other information that you think is relevant to your complaint.

__________________________________________________________________

_________________________________________________________ ___________________________

Signature                                                                                                              Date

Please mail this form to:

MHI-Admin Office

18062 FM 529 #151

Cypress, Texas 77433