

STATE OF VERMONT
OFFICE OF THE ATTORNEY GENERAL
CIVIL RIGHTS UNIT
EMPLOYMENT DISCRIMINATION QUESTIONNAIRE

Does your complaint involve employment? If your answer is NO, the Attorney General's Office Civil Rights Unit will be unable to investigate your complaint. If your answer is YES, please continue with the questionnaire.

If you are a State employee, and you believe you have been discriminated against in employment, or if you believe you have been discriminated against in public accommodations (for example, denial of services in a retail establishment or other business), or in housing, please contact: Vermont Human Rights Commission, 14-16 Baldwin Street, Montpelier, VT 05633-6301, human.rights@vermont.gov, (802) 828-1625 or toll free in Vermont at (800) 416-2010.

If you believe that your employer has engaged in unlawful practices related to your wages or hours (for example, denial of overtime pay), please contact Vermont Department of Labor & Industry, Wage & Hour Division, P.O. Box 488, Montpelier, VT 05601-0488, labor.wagehour@vermont.gov, (802) 828-0267.

This questionnaire is designed to help the Civil Rights Unit determine whether your situation can be investigated by the Attorney General's Office. The Attorney General's Office enforces:

- The Fair Employment Practices Act (banning discrimination in employment),
- The Vermont Parental and Family Leave law,
- The state law banning retaliation or discrimination for asserting a claim to workers compensation,
- The state laws regulating polygraph testing and drug testing by employers,
- The state laws banning discrimination against persons who belong to the National Guard or for taking leave to participate in the Guard, or
- The state law restricting employers from requesting criminal history record information on initial employee application forms ("Ban the Box").

IF YOU BELIEVE that you have been discriminated against or treated unlawfully because of:

- Race,
- Color,
- Religion,
- National origin,
- Sex,
- Ancestry,
- In relation to family or parental leave,
- Place of birth,
- Age,
- Gender Identity,
- Physical or mental condition,
- HIV status,
- Sexual orientation,
- For having asserted a claim or worker's compensation,
- In relation to drug testing or polygraph testing,
- For membership in the National Guard or leave necessitated by service in the Guard,
- In relation to a complaint or investigation of employment discrimination, or
- In relation to criminal history record information obtained by employer during the job application process.

YOU SHOULD FILL OUT THIS QUESTIONNAIRE

Please contact us if you have any questions.

E-Mail: ago.civilrights@vermont.gov

Toll free in Vermont: (888)745-9195 or (802)828-3657

AS YOU FILL OUT THIS QUESTIONNAIRE, BE CAREFUL TO ANSWER EACH QUESTION THAT IS ASKED IN THE SPACES PROVIDED.

If it is difficult for you to fill out this questionnaire FOR ANY REASON, please contact us and we will find another way to get the information.

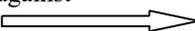
1

INFORMATION ABOUT YOU

Name <input type="text"/>	DOB <input type="text"/>	E-Mail <input type="text"/>
Address <input type="text"/>	Telephone Home: <input type="text"/>	Cell: <input type="text"/>
Town <input type="text"/>	State <input type="text"/>	Zipcode <input type="text"/> (optional) Preferred Pronoun <input type="text"/>
Name, address and telephone number of a person who will know how to reach you if we are unable to:		
<input type="text"/>		

2

INFORMATION ABOUT THE EMPLOYER / EMPLOYMENT AGENCY / UNION

Who is your complaint against (Check all that apply) 	<input type="checkbox"/> Employer	<input type="checkbox"/> Employment Agency	<input type="checkbox"/> Labor Organization
Name <input type="text"/>	President/CEO <input type="text"/>		
Address <input type="text"/>	Your Supervisor <input type="text"/>		
Town <input type="text"/>	Number of Employees:		
State <input type="text"/> Zipcode <input type="text"/>	<input type="checkbox"/> 1 - 4	<input type="checkbox"/> 5 - 9	<input type="checkbox"/> 10 - 14
Telephone <input type="text"/>	<input type="checkbox"/> 15 - 19	<input type="checkbox"/> 20 or More	<input type="checkbox"/> 50 or more within 75 miles
Type of industry (please check one):			
<input type="checkbox"/> Mining	<input type="checkbox"/> Retail Trade	<input type="checkbox"/> Hotels/Lodging Services	
<input type="checkbox"/> Construction	<input type="checkbox"/> Real Estate	<input type="checkbox"/> Health Services	
<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Administration	<input type="checkbox"/> Educational Services	
<input type="checkbox"/> Personal Services	<input type="checkbox"/> Transportation	<input type="checkbox"/> Banking/Finance/Insurance	
<input type="checkbox"/> Auto Repair/Garage	<input type="checkbox"/> Public Utilities	<input type="checkbox"/> Other (Explain)	
<input type="checkbox"/> Recreation Services	<input type="checkbox"/> Wholesale Trade	<input type="text"/>	

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YOUR EMPLOYMENT INFORMATION

Total length of service with the employer you are complaining about: (Please give dates)	From <input type="text"/>	To <input type="text"/>
What was the job you held or were applying for when the actions you are complaining of took place?	<input type="text"/>	
If applicable, how long were you in that job? (Please give dates)	From <input type="text"/>	To <input type="text"/>
What other job titles have you held while employed with this employer (state approximate dates at each position)?	From <input type="text"/>	To <input type="text"/>
	Job Titles <input type="text"/>	
At the time relevant to your complaint, was your work performance rated as satisfactory?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been counseled or reprimanded for any disciplinary matter? If so, as to each incident please state the date, the reason, and the name of the supervisor involved:		
<input type="text"/>		

4

OF THE FOLLOWING FACTORS, WHICH DO YOU BELIEVE CAUSED THE EMPLOYER TO MISTREAT OR DISCRIMINATE AGAINST YOU? (PLEASE CHECK ONLY FACTORS YOU BELIEVE CAUSED MISTREATMENT OR DISCRIMINATION)

<input type="checkbox"/>	Polygraph Testing	<input type="checkbox"/>	Drug Testing
<input type="checkbox"/>	Parental Leave	<input type="checkbox"/>	HIV Status
<input type="checkbox"/>	Family Leave	<input type="checkbox"/>	Sexual Orientation
<input type="checkbox"/>	Medical Leave	<input type="checkbox"/>	Gender Identity
<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	My Perceived Sexual Orientation: <input type="text"/>
	Sex: <input type="text"/>	<input type="checkbox"/>	Filing a discrimination claim
	Age: <input type="text"/>	<input type="checkbox"/>	Asserting a claim for worker's compensation
<input type="checkbox"/>	Race: <input type="text"/>	<input type="checkbox"/>	Mental or Physical Disability: Disability is <input type="text"/>
<input type="checkbox"/>	Color: <input type="text"/>	<input type="checkbox"/>	History of Disability: History of <input type="text"/>
<input type="checkbox"/>	Religion: <input type="text"/>	<input type="checkbox"/>	Perceived Disability: Perceived as <input type="text"/>
<input type="checkbox"/>	Ancestry: <input type="text"/>	<input type="checkbox"/>	Criminal History/Record Information "Ban the Box"
<input type="checkbox"/>	National Origin: <input type="text"/>	<input type="checkbox"/>	Complaining of employment discrimination or cooperating with an investigation into alleged employment discrimination or unlawful action
<input type="checkbox"/>	Place of Birth: <input type="text"/>	<input type="checkbox"/>	Membership in National Guard or leave necessitated by service in the guard
<input type="checkbox"/>	Citizenship Status: <input type="text"/>		

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WHAT HAPPENED THAT YOU WISH TO COMPLAIN ABOUT?
 (CHECK ONLY THOSE THAT YOU BELIEVE WERE CAUSED BY THE UNLAWFUL FACTORS
 YOU CHECKED ON THE PREVIOUS PAGE IN SECTION 4)

<input type="checkbox"/>	I was not hired	<input type="checkbox"/>	I was given benefits not equal to what other employees received
<input type="checkbox"/>	I was fired	<input type="checkbox"/>	I was not paid equally to employees doing the same job as mine, or jobs that require similar knowledge, skills, and responsibility
<input type="checkbox"/>	I was not promoted	<input type="checkbox"/>	I have a disability, which my employer refused to accommodate
<input type="checkbox"/>	My hours were reduced	<input type="checkbox"/>	I was denied parental leave
<input type="checkbox"/>	My shift was changed	<input type="checkbox"/>	I was denied family leave
<input type="checkbox"/>	I was sexually harassed	<input type="checkbox"/>	I was denied medical leave
<input type="checkbox"/>	I was harassed (for reasons not related to my sex)	<input type="checkbox"/>	I was discriminated against because of taking parental leave
<input type="checkbox"/>	I was transferred to another job	<input type="checkbox"/>	I was discriminated against because of taking family leave
<input type="checkbox"/>	I was disciplined	<input type="checkbox"/>	I was discriminated against because of taking medical leave
<input type="checkbox"/>	I was demoted	<input type="checkbox"/>	I was not reinstated to my job upon return from leave
<input type="checkbox"/>	I was laid off	<input type="checkbox"/>	I was treated differently because I was pregnant
<input type="checkbox"/>	I was forced to quit my job	<input type="checkbox"/>	I was asked or required to take a polygraph test
<input type="checkbox"/>	I was not recalled from layoff	<input type="checkbox"/>	I was asked or required to take a drug test
<input type="checkbox"/>	I was denied a raise that I should have gotten	<input type="checkbox"/>	I was asked for criminal history information on initial employee application
<input type="checkbox"/>	I was denied benefits	<input type="checkbox"/>	I was not given a chance to explain the circumstances of my criminal history or rehabilitation.

Listing by **exact date**, please explain in detail what happened. State names of persons involved and dates.

For **each** factor of discrimination or mistreatment you checked in section 4, please describe why you think **that factor** caused the events or actions you checked in section 5.

If the employer stated a reason for the actions or events that you have described, what was that reason? If the employer stated the reason in writing, please mail a copy.

Please state the name and job title of the person who stated the reason, also give the date and place the reason was given.

6 YOUR COMPLAINT AND THE EMPLOYER'S RESPONSE

Did you complain about the unfair events or actions that happened to you (the ones checked in Section 5)? Yes No

If so, please describe your complaint(s), state the name(s) and job title(s) of the person(s) you complained to, and state when you complained.

If not, please explain your reasons:

What action did the employer take in response to your complaint(s)? Please give specific dates and by whom the actions were taken.

7 EMPLOYER'S TREATMENT OF OTHER EMPLOYEES

State the names and job titles of other employees who were treated unfairly **in the same way** you are complaining about.

Were any of these other employees members of **the same protected categories** that you checked in Section 4?

If so, please list their names and the category

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Please give reasons why you think each of these individuals was treated unfairly in the same way you were.

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(a) State the names and job titles of other employees who received **better** treatment than you.

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(b) Were any of these employees members of the same protected categories that you checked on the list in Section 4?

Yes No

If so, which persons are members of which categories?

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(c) Explain your reasons for believing these individuals were treated better than you were.

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8

WITNESSES TO THE DISCRIMINATORY ACTIONS

If you know of witnesses, please list them below. Please provide this information only if it is already known to you. You need to ask to obtain information or statements directly from these potential witnesses. We will contact them when we investigate your charge. For each witness, state their name, address, telephone number and job title (if you don't know the job title, please state whether the person is a co-worker or a supervisor).

Additionally, please briefly describe the information you expect this person to have.

WITNESS #1 Name
Address
Telephone number Job title
(if you don't know the job title, please state whether the person is a co-worker or a supervisor)

Briefly describe the information you expect this person to have.

WITNESS #2 Name
Address
Telephone number Job title
(if you don't know the job title, please state whether the person is a co-worker or a supervisor)

Briefly describe the information you expect this person to have.

WITNESS #3 Name
Address
Telephone number Job title
(if you don't know the job title, please state whether the person is a co-worker or a supervisor)

Briefly describe the information you expect this person to have.

WITNESS #4 Name
Address
Telephone number Job title
(if you don't know the job title, please state whether the person is a co-worker or a supervisor)

Briefly describe the information you expect this person to have.

9**NOTICE OF LEGAL RIGHTS**

Did your employer have a written policy prohibiting harassment?

Yes

No

Was there a poster stating the policy prominently displayed in the workplace?

Yes

No

Did your employer distribute the policy to employees?

Yes

No

Was there a poster regarding Vermont State Parental and Family Leave prominently displayed in the workplace?

Yes

No

10**DISABILITY CLAIMS ONLY**

PLEASE ANSWER THE QUESTIONS IN THIS SECTION ONLY IF YOU BELIEVE THAT THE TREATMENT YOU ARE COMPLAINING ABOUT WAS RELATED TO A DISABILITY.

(a) How are you impaired, physically or mentally, by your disability?

(b) What daily activities are substantially limited (e.g. walking, lifting, standing, breathing, eating, sleeping, etc.), or what are you unable to do because of a disability?

(c) Does your disability limit your ability to perform your job? If so, please describe.

At the time you were discriminated against were you taking any medication, or using any device or method (for example, a prosthesis, eyeglasses, a cane, hearing aid) to assist you in controlling the effects of your impairment?

Yes No

If so, please state what you were taking or using, and explain how it controlled the symptoms or limitations of your impairment. Please also state any side effects or limitations you experienced as a result of any medication, device, etc. you used to treat or manage your impairment.

Was there some accommodation the employer could have made which could have prevented the problem that has led to this complaint? (Accommodations may include: changes in job duties, schedule changes, part-time work, supplying equipment or assistance, transfer to another job, etc.). If so, please describe it specifically.

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(a) Did the employer know about your disability? If so, please explain how the employer knew, state the names of people who knew and the dates they learned of your disability and/or need for accommodations.

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(b) Did the employer know of your need for an accommodation? If so, please explain how the employer knew, state the names of people who knew and the dates they learned of your disability and/or need for accommodations.

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Under penalty of perjury I certify that the information stated by me in this disclosure is true and accurate to the best of my knowledge.

Signature	Date

Please mail your completed Questionnaire and copies of any supporting documents to:

Office of the Attorney General
Civil Rights Unit
109 State Street
Montpelier, VT 05609-1001

or by email to:
ago.civilrights@vermont.gov

You may also contact us by email or by phone if you have any questions:
(888)745-9195 (Toll Free VT)
(802)828-3657