

Utah Antidiscrimination  
 & Labor Division  
 Employment Discrimination  
 160 East 300 South, 3rd Floor  
 PO Box 146630  
 Salt Lake City, UT 84114-6630  
 Phone: 801-530-6801  
 Fax: 801-530-7609  
 Email: discrimination@utah.gov



INTAKE QUESTIONNAIRE

FOH _____	LOH _____
LOR _____	180 _____
Intake _____	300 _____
Waiver _____	ADA _____

(Do Not Mark in this Space) 5/15

**THIS FORM DOES NOT REPRESENT A CHARGE OF DISCRIMINATION WITH THE DIVISION.** In order to file a Charge with the Division, you must complete and return this form. The Division will use the information in this Intake Form to draft a separate Charge which will be mailed to you. You will then need to sign the Charge and have it notarized. The Division can formally open a case only after it has received your signed, notarized Charge.

You must complete all pages. We are unable to process forms that are incomplete and this form may be rejected until we receive the missing information. Your charge cannot be processed unless this form is complete. If you need help filling out this form, please contact us either by phone or email. You must write legibly.

**SECTION 1: YOU**

Your Name:		Email Address:		Date of Birth:	
Mailing Address:			Apt #:	City:	
Telephone #:		Cell #:		State:	Zip:
Name, address & telephone number of nearest relative or contact person not living with you (as a way to locate you if the Division cannot contact you):					
Are you represented by a lawyer? <input type="checkbox"/> No <input type="checkbox"/> Yes		Lawyer's Name:		Phone:	
<p><b>**Before the Division can talk to your lawyer about this case, please have your lawyer submit a "Letter of Representation." Until then, Division staff cannot communicate with your lawyer.</b></p> <p>If you would like the Division to be able to communicate on your behalf with someone other than a lawyer (spouse, parent, advocate, etc.), you will need to submit a separate signed letter with the name and contact information of that person. The Division can provide you with a form letter for you to complete.</p>					

This information is used for internal statistical purposes only:		
How did you hear about UALD?		
Race:	National Origin:	Gender:

**SECTION 2: YOUR EMPLOYER**

Name of the Employer You are Filing Against:		Telephone #	
Address of where you worked:		Website (If known):	
City:	State:	Zip:	
Name of Corporation OR Name of your employer listed on your W2 Tax form OR Name of employer listed on your paycheck:			
Name of Employer's Highest Official:		Telephone #	

Address:		
City:	State:	Zip:
Does your employer have at least 15 Employees in Utah?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know	
How many employees does the company have nation-wide?	<input type="checkbox"/> Less than 15 <input type="checkbox"/> 15 - 100 <input type="checkbox"/> 101 -200 <input type="checkbox"/> 201 - 500 <input type="checkbox"/> 500+	
Were you also employed by a staffing agency?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, a second intake questionnaire will need to be filed for the staffing agency.		
Were you discriminated against/harassed because of a disability?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
If Yes, you must fill out and submit the additional ADA Questionnaire.		

### SECTION 3: YOUR EMPLOYMENT WHERE YOU EXPERIENCED DISCRIMINATION

Date of Hire:	Job Title:	Rate of Pay:
Name and title of your manager:		Are you still working there? <input type="checkbox"/> No <input type="checkbox"/> Yes
Did you quit? <input type="checkbox"/> No <input type="checkbox"/> Yes When? (dd/mm/yyyy)	Were you forced to quit? <input type="checkbox"/> No <input type="checkbox"/> Yes When? (dd/mm/yyyy)	Were you terminated? <input type="checkbox"/> No <input type="checkbox"/> Yes When? (dd/mm/yyyy)
If you were terminated, what reason did your employer give for your termination?		

### SECTION 4: HARM SUFFERED

**\*If you are claiming you were denied your religious liberties, please go to Section 6**

<b>#1 - Harassment:</b> Did someone at your work harass you? <input type="checkbox"/> No (If no, skip to #2) <input type="checkbox"/> Yes	
First Date of Harassment:	Last Date of Harassment:
Who harassed you? Name _____ Title: _____	
Were you harassed because of your:	
<input type="checkbox"/> <b>Age</b> - Date of birth: _____	
<input type="checkbox"/> <b>Pregnancy</b>	
<input type="checkbox"/> <b>Gender</b> - <input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> <b>Sexual Orientation</b> - <input type="checkbox"/> Actual <input type="checkbox"/> Perceived	
<input type="checkbox"/> <b>Gender Identity</b>	
<input type="checkbox"/> <b>Religion</b> - Specify your closely held religious beliefs: _____	
<input type="checkbox"/> <b>Disability:</b> _____	
Briefly describe your disability and <i>attach the separate ADA Questionnaire. If you are claiming that your employer failed to accommodate your disability, please complete #4 below.</i>	
<input type="checkbox"/> <b>Race/Ethnicity:</b> <input type="checkbox"/> Black <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Other - Specify: _____	
<input type="checkbox"/> <b>Color</b> - Specify: _____	
<input type="checkbox"/> <b>National Origin/Ancestry:</b> <input type="checkbox"/> Mexican <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> East Indian <input type="checkbox"/> Arab/ Middle Eastern <input type="checkbox"/> Other - Specify _____	
How often would the harassment occur?	
When was the first time it happened?	When was the last time it happened?
What was the single worst thing that the harasser did/said? (You can provide more details Section 6 below.)	

Did you complain about the harassment? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please make sure to complete #4 - Retaliation below.)
If no, why didn't you complain?
If yes, who did you complain to? Name _____ Job title _____ When _____
Briefly describe what happened because you complained. (You can provide more details in Section 6 below.) _____ _____ _____

<b>#2 - Discrimination.</b> Were you treated differently than others around you at work? <input type="checkbox"/> No (If no, skip to #4) <input type="checkbox"/> Yes
Protected Class. You must claim that you were discriminated against/treated differently because you belong to at least one of the following protected classes. Were you treated differently because of your: (check all that apply)
<input type="checkbox"/> <b>Age</b> - Date of birth: _____
<input type="checkbox"/> <b>Pregnancy</b>
<input type="checkbox"/> <b>Gender</b> - <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> <b>Sexual Orientation</b> - <input type="checkbox"/> Actual <input type="checkbox"/> Perceived
<input type="checkbox"/> <b>Gender Identity</b> - <input type="checkbox"/> Refused Accommodation
<input type="checkbox"/> <b>Religion</b> - Specify your closely held religious beliefs: _____ <input type="checkbox"/> Refused Accommodation
<input type="checkbox"/> <b>Disability</b> : _____ Briefly describe your disability and <i>attach the separate ADA Questionnaire. If you are claiming that your employer failed accommodate your disability, please complete #4 below.</i>
<input type="checkbox"/> <b>Race/Ethnicity</b> : <input type="checkbox"/> Black <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Native American <input type="checkbox"/> Other - Specify: _____
<input type="checkbox"/> <b>Color</b> - Specify: _____
<input type="checkbox"/> <b>National Origin/Ancestry</b> : <input type="checkbox"/> Mexican <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> East Indian <input type="checkbox"/> Arab/ Middle Eastern <input type="checkbox"/> Other - Specify: _____
How were you treated differently?
<input type="checkbox"/> Terminated Date: _____ <input type="checkbox"/> Constructively Discharged Date: _____
<input type="checkbox"/> Laid Off Date: _____ <i>(things were so bad you felt like you had to resign)</i>
<input type="checkbox"/> Not Promoted Date: _____ <input type="checkbox"/> Terms and conditions <i>(work hours, etc.)</i> Date: _____
<input type="checkbox"/> Suspended Date: _____ <input type="checkbox"/> Disciplined Date(s): _____
What reasons (if any) were given to you for the acts you consider discriminatory? By whom? Their job title? _____ _____ _____ _____

Of the persons in the same or similar job as you had, who was treated <i>better</i> than you?			
Name	race/color/religion/sex/age/ national origin /disability/ sexual orientation/gender identity of that person	Job Title	Description of Treatment

Of the persons in the same or similar job as you had, who was treated <i>worse</i> than you?			
Name	race/color/religion/sex/age/ national origin /disability/ sexual orientation/gender identity of that person	Job Title	Description of Treatment

Of the persons in the same or similar job as you had, who was treated <i>the same as you</i> ?			
Name	race/color/religion/sex/age/ national origin /disability/ sexual orientation/gender identity of that person identity of that person	Job Title	Description of Treatment

**#3 – Disability Discrimination/Failure to Accommodate.** Did you ask your employer to modify your job duties, your work environment or otherwise to provide you with a reasonable accommodation for your disability?  No  Yes

- If you're claiming discrimination based on your disability, you must also complete an ADA Questionnaire available on the website.
- If yes, briefly describe the accommodation you were requesting and what your employer did in response.

---



---



---



---

**#4 - Retaliation.** Did you complain to your employer about discrimination/harassment?  No  Yes  
 (Please note that the Division can only investigate claims of retaliation where you specifically complained of or opposed discrimination)

Date you complained: (mm/dd/yyyy) _____	Who did you complain to? Name: _____ Job Title: _____
--	--

You complained of Harassment based on: <input type="checkbox"/> Age <input type="checkbox"/> Religion <input type="checkbox"/> Pregnancy <input type="checkbox"/> Disability <input type="checkbox"/> Gender <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Sexual Orientation <input type="checkbox"/> Color <input type="checkbox"/> Gender Identity <input type="checkbox"/> National Origin/Ancestry	You complained of Discrimination based on: <input type="checkbox"/> Age <input type="checkbox"/> Religion <input type="checkbox"/> Pregnancy <input type="checkbox"/> Disability <input type="checkbox"/> Gender <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Sexual Orientation <input type="checkbox"/> Color <input type="checkbox"/> Gender Identity <input type="checkbox"/> National Origin/Ancestry
---	---

Please summarize the complaint you made. (You can provide more details in Section 6 below.) *You must have complained about discrimination and/or harassment based on age (over 40), race, national origin, disability, religion, gender, sexual orientation or gender identity to be protected by the anti-retaliation provision of the law)*

\_\_\_\_\_

\_\_\_\_\_

Briefly describe whatever harm happened to you after you complained. (You can provide more details in Section 6 below.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**#5 – What relief are you seeking?** i.e. back wages, reinstatement, or other. (please specify)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

[Continue on Page 6]



