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 flied 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