



CITY OF ASTORIA

1095 Duane Street
Astoria, Oregon 97103
www.astoria.gov

Phone (503) 325-5821, 711 (TTY)
Fax (503) 325-2997
Email: rquigly@astoria.gov

Report of Discrimination Form for the Public

Do you need help filling out this form?

Call 503-325-5824 or 711 (TTY) for help if you need an interpreter;

- This form in another language;
- This form in larger print or other format;
- Answers to your questions about this form.

All services named above are free

Do you want to report discrimination in one of the City of Astoria's programs that occurred or you became aware of within the last 60 days? If so, fill out this important form.

Please complete this form to report discrimination based on any of these factors:

- Sexual orientation;
- Gender identity;
- Race;
- Color;
- National origin;
- Limited English proficiency;
- Religion;
- Disability;
- Age;
- Sex (gender);
- Pregnancy;
- Sexual harassment;
- Marital status;
- Retaliation for filing a report of discrimination; or
- Any other class protected by law

The City of Astoria City Manager or designee will carefully review the information on this form.

You will get a letter from us no more than seven days after we receive this form. It will tell you that we got your report of discrimination and if the City has the authority to act on it. If the City of Astoria cannot act on your report, we will tell you which office can act on it.

It is the City of Astoria's policy not to intimidate, threaten, coerce, discriminate or retaliate against you for making a report of discrimination.

Information about the Report of Discrimination

Please print or type — attach extra pages, if necessary.

Date: _____

1A. _____

Name of person who experienced alleged discrimination

Address	City	State	ZIP code
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Home phone / cell phone	Work phone	Other
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Date of birth	Preferred language
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How would you like us to contact you? Phone Email Other

Best time to contact you: _____ (Day/time)

May we contact you by email? Yes No Email: _____

If you are making this report of discrimination for someone else, please fill out the information below:

1B. _____

Name of person completing this form for person who experienced the alleged discrimination

Address	City	State	ZIP code
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Home phone / cell phone	Work phone	Other
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Preferred language

How would you like us to contact you? Phone Email Other

Best time to contact you: _____ (Day/time)

May we contact you by email? Yes No Email: _____

2. Please give us information about the individual/group/ you believe discriminated.

Name(s)/ Description

Phone number *(if known)*

Most recent date(s) of when alleged discrimination occurred

Did the alleged discrimination happen more than 60 days ago? Yes No

If yes, please tell us why you are making this Report of Discrimination now:

3. Were you denied access to a facility or building? Yes No

Building/facility name

Street address

City

State

ZIP code

4. Were you denied access to or participation in a program, service or activity? Yes No

If yes, please fill out the information below:

Program name

Date

Time

5. Tell us what happened. Please include the information below:

- A list of all the people involved, including first and last names and titles, if known;
- Exact words or actions of the people involved;
- Date(s);
- Time(s);

6. Witnesses:

List the full name and contact information of anyone who may have seen or heard the alleged discrimination. Please provide as much information as possible.

7. Have you tried to solve the problem or contact anyone else with your report?

If yes, who have you contacted? What happened?

8. What would you like to see happen with this report?

9. Do you believe that your protected class was the reason for the discrimination? Yes No

If yes, please check all boxes that apply.

Age

Religion

Disability

Pregnancy

Sex (gender)

Sexual harassment

Marital status

Retaliation for filing a Report of Discrimination

National origin

Limited English proficiency

Race

Sexual orientation

Color

Gender identity

Other: _____

This form was filled out by:

The person against whom the alleged discrimination occurred

Attorney/representative/advocate

OHA employee: _____

Other (*please specify*): _____

Please attach any other information related to your Report of Discrimination.

PLEASE RETURN THIS FORM TO:

City of Astoria

Office of the City Manager

1095 Duane Street, Astoria OR 97103

Fax 503-325-2017 or email requestforservice-cm@astoria.gov

503-325-5824 (voice) or 711 (TTY)

You may also have the right to file a complaint with one of the following agencies:

Oregon Health Authority (OHA)

Web: www.oregon.gov/OHA/EOI

Email: OHA.PublicCivilRights@state.or.us

Phone: (844) 882-7889, 711 TTY

Mail: Office of Equity and Inclusion Division, 421 SW oak St., Suite 750, Portland, OR 97204

Within one year of the date of the alleged discrimination:

Bureau of Labor and Industries (BOLI) Civil Rights Division

Web: www.oregon.gov/BOLI

Email: crdemail@boli.state.or.us

Phone: (971)673-0764, 711 TTY

Mail: 800 NE Oregon St., Suite 1045, Portland, OR 97232

Within 180 days of the alleged discrimination:

U.S. Department of Health and Human Services, Office for Civil Rights (OCR)

Web: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Email: OCRComplaint@hhs.gov

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: 200 Independence Avenue SW., Room 509F HHH Building, Washington, DC 20201.

Complaint forms are available at: www.hhs.gov/ocr/office/file/index.html

U.S. Department of Justice (USDOJ), Civil Rights Division

Web: <https://civilrights.justice.gov/>

Phone: 1-855-856-1247, (202) 514-0716 (TTY)

Mail: 950 Pennsylvania Avenue, NW, Washington, D.C. 20530-0001