



**St. Johns County  
Discrimination Complaint Form**

<b>Section I:</b>				
Name:				
Address:				
Telephone (Home):			Telephone (Work):	
Electronic Mail Address:				
Accessible Format Requirements?	Large Print		Audio Tape	
	TDD		Other	
<b>Section II:</b>				
Are you filing this complaint on your own behalf?			Yes*	No
*If you answered "yes" to this question, go to Section III.				
If not, please supply the name and relationship of the person for whom you are complaining:				
Please explain why you have filed for a third party: _____				
Please confirm that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party.			Yes	No
<b>Section III:</b>				
I believe the discrimination I experienced was based on (check all that apply):				
Title VI, Civil Rights Act: <input type="checkbox"/> Race <input type="checkbox"/> Color <input type="checkbox"/> National Origin <input type="checkbox"/> Age				
Title II, ADA: <input type="checkbox"/> Disability				
<input type="checkbox"/> Other				
Date of Alleged Discrimination (Month, Day, Year): _____				
Explain as clearly as possible what happened and why you believe you were discriminated against. Describe all persons who were involved. Include the name and contact information of the person(s) who discriminated against you (if known) as well as names and contact information of any witnesses. If more space is needed, please use the back of this form.				
<b>Section IV</b>				
Have you previously filed a discrimination complaint with this agency?			Yes	No

<b>Section V</b>	
Have you filed this complaint with any other Federal, State, or local agency, or with any Federal or State court?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, check all that apply:	
<input type="checkbox"/> Federal Agency: _____	
<input type="checkbox"/> Federal Court _____	<input type="checkbox"/> State Agency _____
<input type="checkbox"/> State Court _____	<input type="checkbox"/> Local Agency _____
Please provide information about a contact person at the agency/court where the complaint was filed.	
Name:	
Title:	
Agency:	
Address:	
Telephone:	
<b>Section VI</b>	
Name of agency complaint is against:	
Contact person:	
Title:	
Telephone number:	

You may attach any written materials or other information that you think is relevant to your complaint. Signature and date required below

\_\_\_\_\_

Signature Date

Please submit this form in person at the address below, or mail this form to:

St. Johns County  
 Title VI/ADA Coordinator  
 500 San Sebastian View, Room 005A  
 St. Augustine, FL 32084

Or

Executive Director  
 St. John County Council on Aging, Inc.  
 180 Marine St.  
 St. Augustine FL 32084

Or

Director, FTA Office of Civil Rights  
 East Building, 5<sup>th</sup> Floor - TCR  
 1200 New Jersey Ave. SE  
 Washington, D.C. 20590