

**PA Human Relations Commission Use Only**

Revised 08.05

Docket No. \_\_\_\_\_

EEOC No. \_\_\_\_\_

Social Security No. \_\_\_\_\_

PHRC can investigate complaints of discrimination in: (1) Employment based upon race, color, religion, ancestry, age (40 and above), sex, national origin, non-job related handicap or disability, known association with a handicapped or disabled individual, possession of a diploma based on passing a general education development test, or willingness or refusal to participate in abortion or sterilization.

## IN-18 FORM - FAILURE TO ACCOMMODATE QUESTIONNAIRE

Questionnaire on the incident you are complaining about

To avoid rewriting your answers, please read this short questionnaire from beginning to end before filling out your answers to individual questions. Please answer every applicable question as fully as possible, and to the best of your present knowledge, information and belief. If you are unsure of your answer, please say so. It is your responsibility to notify this Agency of a change of address or times of unavailability. Failure to notify this Agency may result in dismissal of the matter.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

County \_\_\_\_\_ Phone H: \_\_\_\_\_ Phone W: \_\_\_\_\_

May we call you at work? (Circle one)      **YES**      **NO**

Caution: Failure to correctly identify the name of the legal entity you are complaining about will hinder the processing of your complaint. Bring pay stubs, W-2 forms, contracts, etc. to aid in verification of the name and address.

**Information about the Organization your complaint is against:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Type of Business \_\_\_\_\_

County \_\_\_\_\_ Phone No. \_\_\_\_\_

Number of employees who work at the organization named above. Please circle one.

- |             |            |            |         |
|-------------|------------|------------|---------|
| Less than 4 | 15 to 100  | 201 to 500 | Unknown |
| 4 to 14     | 101 to 200 | 501 plus   |         |

Name and address of person who will know how to contact you and who does not reside in your home.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone No. Home \_\_\_\_\_ Phone No. Work \_\_\_\_\_

In this Questionnaire, you will see the word "class" mentioned. **Class means the person's race, sex, age, ancestry, religion and so on.** Depending on the issues in the complaint, you may belong to two or more classes. For example, a Black female could belong to two classes: race/Black and sex/female. A White male could belong to race/White and sex/male. All persons named in the complaint or questionnaire should be identified by their class as follows: John Doe (White male), John Doe (under age 40), Jane Doe (Black female). or example, if your complaint is based on race, include the race of all persons mentioned. If it is a sex complaint, mention the sex of all persons mentioned.

1 **Discrimination means difference of treatment.** Please explain what happened to you and why you feel you were treated differently. In other words, what happened to persons of a different class that makes you feel they received more favorable treatment than you. Give specific dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2 If you believe the organization treated you this way because of one or more of the reasons listed below, please check those reasons. If you believe the employer treated you this way for a reason which is not listed, explain what you believe to be the reason.

- \_\_\_\_\_ Sex                      \_\_\_\_\_ National Origin
- \_\_\_\_\_ Race                    \_\_\_\_\_ Age                      Date of Birth \_\_\_\_\_
- \_\_\_\_\_ Color                    \_\_\_\_\_ GED
- \_\_\_\_\_ Religion                \_\_\_\_\_ Retaliation
- \_\_\_\_\_ Ancestry                \_\_\_\_\_ Use of guide dog or support animal
- \_\_\_\_\_ Non-job related disability

Identify your disability: \_\_\_\_\_

\_\_\_\_\_ Participation in/or refusal to participate in Abortion/sterilization

3 What is the exact nature of your disability and to what extent does it limit such major life activities such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4 How long have you had this condition? \_\_\_\_\_

5 How long is your condition expected to last? \_\_\_\_\_

6 What types of physical activity are difficult or impossible for you to perform? (Please circle.)

- |         |          |           |                           |
|---------|----------|-----------|---------------------------|
| Visual  | Bending  | Dexterity | Standing for long periods |
| Hearing | Stooping | Running   | Sitting for long periods  |
| Walking | Turning  | Swallowin | Performing manual tasks   |
| Lifting | Climbing | Other**   | Caring for yourself       |

If \*\*other, please explain. \_\_\_\_\_

**Please provide copies of any medical information, certifications, etc. regarding your disability.**

7 Do you have any restrictions on mental activities? **YES** **NO**

If yes, please explain. \_\_\_\_\_

8 Please provide names and addresses of doctors, hospitals, counselors, organizations, etc., who may be able to provide data concerning your disability and the extent of any treatment or specialized training you have had or are receiving.

Name/Title \_\_\_\_\_

Address \_\_\_\_\_

Treatment/Training \_\_\_\_\_

Name/Title \_\_\_\_\_

Address \_\_\_\_\_

Treatment/Training \_\_\_\_\_

Name/Title \_\_\_\_\_

Address \_\_\_\_\_

Treatment/Training \_\_\_\_\_

9 Do you have a physician, health service or rehabilitation clinic that has/will certify that you can perform the job in question with or without reasonable accommodation?

YES NO

If yes, please provide names and addresses.

Name/Title \_\_\_\_\_

Address \_\_\_\_\_

Name/Title \_\_\_\_\_

Address \_\_\_\_\_

Name/Title \_\_\_\_\_

Address \_\_\_\_\_

10 Do you know of others in your CLASS who have received the same or similar conditions? Please indicated their names, addresses, phone numbers and their CLASS.

Name \_\_\_\_\_

Class (race, sex, age, etc.) \_\_\_\_\_

Phone No. \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Class (race, sex, age, etc.) \_\_\_\_\_

Phone No. \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Class (race, sex, age, etc.) \_\_\_\_\_

Phone No. \_\_\_\_\_

Address \_\_\_\_\_

11 Do you know of others treated differently under the same or similar conditions? Please indicated their names, addresses, phone numbers and their CLASS.

Name \_\_\_\_\_

Class (race, sex, age, etc.) \_\_\_\_\_

Phone No. \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Class (race, sex, age, etc.) \_\_\_\_\_

Phone No. \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Class (race, sex, age, etc.) \_\_\_\_\_

Phone No. \_\_\_\_\_

Address \_\_\_\_\_

11a How were they treated differently? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12 If the physician, etc., stated you could perform the job with a reasonable accommodation, did you request this accommodation?

**YES NO**

12a From whom did you request this reasonable accommodation? (Provide name and title)

12b Was any cost attached to the reasonable accommodation? **YES NO**

If yes, approximately how much would these accommodations cost, including special equipment, building renovations and work force changes.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12c When did the employer become aware of the certification that you could perform the job with or without reasonable accommodation?

Date \_\_\_\_\_

Did the respondent refuse the request for a reasonable accommodation? **YES NO**

12d When (what date) was the reasonable accommodation refused? \_\_\_\_\_

12e Who refused the reasonable accommodation? (Please give name and title).

\_\_\_\_\_

12f What reason(s) was given, if any?

\_\_\_\_\_

\_\_\_\_\_

13 Did the Respondent offer another or different accommodation? **YES** **NO**

13a If yes, what was it?

\_\_\_\_\_

13b Did you and/or your doctor refuse it? **YES** **NO**

If yes, why?

\_\_\_\_\_

\_\_\_\_\_

14 Do you have any receipts or documents to back-up what you are saying? **YES** **NO**

15 Do you have any witnesses to this treatment? **YES** **NO**

If yes, please provide the name(s).

Name/Title

\_\_\_\_\_

Class (race, sex, age, etc.)

\_\_\_\_\_

Phone No.

\_\_\_\_\_

Address

\_\_\_\_\_

What will this person say?

\_\_\_\_\_

\_\_\_\_\_

Did he/she personally observe what happened? **YES** **NO**

Name/Title

\_\_\_\_\_

Class (race, sex, age, etc.)

\_\_\_\_\_

Phone No.

\_\_\_\_\_

Address

\_\_\_\_\_

What will this person say?

\_\_\_\_\_

\_\_\_\_\_

Did he/she personally observe what happened? **YES** **NO**

Use the Continuation Page at the back of the questionnaire, if more space is needed.

16 Have you taken any court action regarding this matter? If so, please specify in what court and the date you filed, to the best of your recollection.

Name of Court \_\_\_\_\_  
Date Filed \_\_\_\_\_  
City \_\_\_\_\_  
County \_\_\_\_\_  
State \_\_\_\_\_

If there are other facts you feel should be considered, record these on the last page of the questionnaire (Continuation Page).

**I hereby verify that the statements contained in this complaint are true and correct to the best of my knowledge, information and belief. I understand that false statements herein are made subject to the penalties of 18 PA.C.S. Section 4904, relating to unsworn falsification to authorities.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Phone No. Home \_\_\_\_\_

Phone No. Work \_\_\_\_\_

Phone No. Cell \_\_\_\_\_

