Clatsop County

Department of Public Health
820 Exchange St., Suite 100
Astoria, Oregon 97103
www.co.clatsop.or.us/publichealth

Phone (503) 325-8500, 711 (TTY)
Fax (503) 325-8678
Email: health@co.clatsop.or.us

Report of Discrimination Form for the Public

Do you need help filling out this form?

Call 503-325-8500 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 Clatsop County Public Health'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 Clatsop County Department of Public Health Civil Rights Coordinator 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 Clatsop County Department of Public Health has the authority to act on it. If Clatsop County Department of Public Health cannot act on your report, we will tell you which office can act on it.

It is Clatsop County Department of Public Health'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

_____ _____ _____
Home phone / cell phone Work phone Other

_____ _____
Date of birth 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:_____

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

_____ _____ _____
Home phone / cell phone Work phone Other

_____
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:

Clatsop County Department of Public Health
820 Exchange St. Suite 100, Astoria OR 97103
Fax 503-325-8678 or email health@co.clatsop.or.us
503-325-8500 (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