



**NAACP**  
PO BOX 2165  
ROCKVILLE, MARYLAND 20847-2165

# COMPLAINT FORM

1. Complainant's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: Residence: \_\_\_\_\_ Business: \_\_\_\_\_

2. List the name of the person this claim is processed for if different from the name above:

Name & Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: Residence: \_\_\_\_\_ Business: \_\_\_\_\_

3. Type of Complaint: \_\_\_\_\_

(For discrimination claim describe)  
National Origin: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Disability: \_\_\_\_\_

4. Name & Address of agency or organization this claim is filed against:  
\_\_\_\_\_  
\_\_\_\_\_

5. Summarize your claim below; include dates and times of events, names and titles of all individuals(s) involved. Attach additional sheets and any documents that may support your claim.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_