



**Hope Clinic for Women
Title VI Complaint Form**

Complaints must be filed within 180 days of the alleged act of discrimination.

1. What is the name of the person discriminated against?

Name _____

Address _____

City, State, and Zip Code _____

Telephone (*Home*) (_____) _____ (*Business*) (_____) _____

2. What is the name and address of the institution, agency, or person that you believe discriminated against you?

Name _____

Address: _____

City, State, and Zip Code _____

Telephone Number (_____) _____

3. What was the reason you believe you were discriminated against? Was it because of your:

a. Race

b. Color

c. National Origin

4. When do you believe that the discrimination took place? _____

5. In your own words, explain what happened and who you believe was responsible. Please be as specific as possible. You may attach additional sheets if needed.

7. Are you filing this complaint for someone else? Yes No

If yes, against whom do you believe the discrimination was directed?

First Name _____ Last Name _____

8. Have you filed this complaint with any other federal, state, or local agency, or with any federal or state court? Yes No

If yes, check all that apply:

Federal agency Federal court State agency State court Local agency

9. What is the name of the contact person at the agency/court where the complaint was filed?

Name _____

Agency/Court Name _____

Address _____

City, State, and Zip Code _____

Telephone Number (_____) _____

10. Please sign below. You may attach any written materials or other information that you think can be helpful to us in looking into your complaint.

Complainant's Signature

Date

This form may be mailed to:

Emmely Duncan
Hope Clinic for Women
1810 Hayes Street
Nashville, TN 37203