

SOUTH CAROLINA HUMAN AFFAIRS COMMISSION

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Columbia, South Carolina 29201

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NON-EMPLOYMENT INITIAL INQUIRY QUESTIONNAIRE

Complete all applicable portions.

Type or Print in ink only.

Do not write on the back of any page in this Questionnaire.

**COMPLETION AND SUBMISSION OF THIS QUESTIONNAIRE DOES NOT IMPLY OR
CONSTITUTE THE FILING OF A COMPLAINT.**

Full Legal Name: _____
(First) (Middle) (Last)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: Home (_____) _____ Work: (_____) _____
(Area Code) (Area Code)

Cell: (_____) _____ Beeper: (_____) _____
(Area Code) (Area Code)

E-mail Address: _____

Date of Birth: _____ Age: _____ Sex (Circle one): M F

Race (Circle one): ___Black ___White ___Asian/Pacific Islander ___American Indian/Alaskan Native ___Other

National Origin (Circle one): ___Arab/Afghani ___East Indian ___Hispanic ___Mexican ___Other

Religion: _____

Do you have a disability? ___ Yes ___ No If yes, what is your disability? _____

Are you perceived as being disabled? ___ Yes ___ No If yes, explain: _____

1. What business, organization or company allegedly harmed you? (Give the South Carolina name and address)

Business Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (_____) _____
(Area Code)

2. Have you filed this complaint in court or with another agency? ___ Yes ___ No If yes, complete the following about the individual in the court or agency to whom you complained:

Name: _____

Title: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

When did you file this complaint? _____

3. Date of the alleged harm: _____

4. Who allegedly harmed you?

Name: _____

Title: _____

Race: _____ Sex: _____ Age: _____ National Origin: _____ Religion: _____

5. Which of the following do you believe was the reason you were harmed?

_____ Race _____ Sex _____ Age (over 40)

_____ National Origin (Ancestry) _____ Color

_____ Religion (*you were denied a reasonable accommodation for your religious beliefs*)

_____ Disability (*you were denied a reasonable accommodation for your disability*)

6. Provide a brief explanation of what happened and when it happened to you. Identify the people involved by name, race, and sex. (Attach additional pages as necessary - **DO NOT WRITE ON THE BACK OF THIS FORM**)

7. Were you given any reason for the treatment you received? _____ Yes _____ No If yes, what was the reason?

8. Were other individuals treated better than you under the same or similar circumstances? _____ Yes _____ No If yes, complete the following information that applies to your situation:

<i>Name</i>	<i>Race</i>	<i>Color</i>	<i>Sex</i>	<i>Age</i>	<i>National Origin</i>	<i>Religion</i>
<i>Brief description of this individual's treatment</i>						
<i>Name</i>	<i>Race</i>	<i>Color</i>	<i>Sex</i>	<i>Age</i>	<i>National Origin</i>	<i>Religion</i>
<i>Brief description of this individual's treatment</i>						
<i>Name</i>	<i>Race</i>	<i>Color</i>	<i>Sex</i>	<i>Age</i>	<i>National Origin</i>	<i>Religion</i>
<i>Brief description of this individual's treatment</i>						

9. Were there any witnesses to the events? __ Yes __ No

10. Do those individuals have relevant, first-hand information that is material to this complaint? __ Yes __ No

11. Are those individuals willing to speak with the Commission about this complaint? __ Yes__ No If yes, please provide the following information on each individual: (Attach extra sheets for additional witnesses)

Witness Name: _____
(First) (Middle) (Last)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: Home (_____) _____ Work: (_____) _____
(Area Code) (Area Code)

Cell: (_____) _____ Beeper: (_____) _____
(Area Code) (Area Code)

E-mail Address: _____

Settlement Information

12. What is the minimum relief you would accept to settle this complaint?

Contact Information

Provide the following information on how the Commission may contact you during the Commission's regular workday hours.

Home: (____) _____ Hours: _____
Work: (____) _____ Hours: _____

Provide the following information on a person who will know where you can be reached. This individual should be someone who DOES NOT LIVE with you.

Full Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone Number: Home (____) _____ Work: (____) _____

Do you have an attorney representing you in this matter? _____ Yes _____ No If yes, your attorney must send a *Letter of Representation* to the South Carolina Human Affairs Commission. The Commission cannot discuss any matter pertaining to your complaint with the attorney until it receives the Letter of Representation.

It is your responsibility to immediately notify the Commission if you change your address or telephone number. If you cannot be contacted because you have not met these responsibilities, your complaint may be dismissed. You must provide a telephone number by which the investigator can contact you during the Commission's normal business hours (8:30 A.M. to 5:00 P.M. Monday through Friday).

I have read (or it has been read to me) this document and understand the above information. I understand that the South Carolina Human Affairs Commission makes no promises or guarantees to me as to the possible outcome or results of this complaint. I certify that all of the information contained in this questionnaire is true, accurate, and factual to the best of my knowledge, information and belief.

Signature of Complainant: _____ Date: _____