

PICKENS COUNTY GOVERNMENT TITLE VI COMPLAINT FORM

NAME				
STREET ADD	DRESS			
			PERSON WHO DISCRIMINATED	AGAINST YOU:
NAME				
PLEASE IDE	NTIFY ANY WIT	NESSES TO THE	E DISCRIMINATION AND PROVI	DE CONTACT INFO:
WITNESS	NAME			
WITNESS				
WITNESS				
				
DATE(S) OF	DISCRIMINATI	ON COMPLAINI	ED OF	
I WAS DISC	RIMINATED AG	AINST BECAUS	E OF (CHECK ONE):	
RACE		COLOR	NATIONAL ORIGIN	DISABILITY

PLEASE EXPLAIN WHAT HAPPENED DESCRIBING HOW YOU WERE DISCRIMINATED AGAINST AND WHO WAS INVOLVED. BE SURE TO INCLUDE HOW OTHER PERSONS WERE TREATED DIFFERENTLY THAN YOU. ATTACH ANY WRITTEN MATERIAL YOU MAY HAVE THAT SUPPORTS YOUR CLAIM TO DISCRIMINATION.					
PLEASE RETURN THIS FORM TO:					
PICKENS COUNTY GOVERNMENT					
TITLE VI COORDINATOR					
HUMAN RESOURCES DEPARTMENT					
222 MCDANIEL AVE B-14					
PICKENS, SC 29671					
SIGNATURE DATE					