



# FAIR EMPLOYMENT PRACTICE OFFICE INQUIRY QUESTIONNAIRE

414 West Soledad Avenue  
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Hagatna, GU 96910  
Telephone: (671) 300-4544  
Fax: (671) 475-6811

Thank you for contacting the Fair Employment Practice Office ("FEPO"). Complete this inquiry Questionnaire if you would like to begin the process of filing a charge of employment discrimination with the FEPO or if you would like to discuss your concerns with the FEPO. Please note: This Questionnaire is not a Charge of Discrimination. The information you give us on this Questionnaire will help us assist you and determine if your concerns are covered by the employment discrimination laws we enforce. Answer all questions completely and briefly. Please make sure your answers can be easily read. After completing this Questionnaire, return it immediately to FEPO office identified in the cover letter to this Questionnaire, or to the office assistant if you are completing this Questionnaire in office.

Please note that this Questionnaire is not intended for use by applicants for federal jobs or employees of the Government of Guam. For information about complaints of job discrimination in local, private, or federal employment, see <http://dol.guam.gov/>

## Personal Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. or Unit #: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

What is the best way to reach you? \_\_\_\_\_

What are the best days and times to reach you? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

### ----- General information about you that will allow us to serve all individuals better: -----

i. Are you Hispanic or Latino?  Yes  No

ii. Do you have a disability?  Yes  No

iii. What is your race? **Please choose all that apply:**  American Indian or Alaskan Native  Asian  White

Black or African American  Native Hawaiian or Other Pacific Islander

iv. What is your National Origin (country of origin or ancestry)? \_\_\_\_\_

## Who can we contact if we are unable to reach you?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

## Who do you believe discriminated against you?

Check all that apply:  Employer  Union  Employment Agency  Other Organization

Organization Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Human Resources Director or Owner: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone number of organization: (\_\_\_\_) \_\_\_\_\_

How many employees (estimated) does the organization have at all locations? Please check one:

Less than 15  15-100  101-200  201-500  More than 500

Actual job location (address) where you work(ed) or applied for Job (if different for the organization address): Street

Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**THIS QUESTIONNAIRE IS NOT A CHARGE OF DISCRIMINATION**

**What was the negative job action taken against you that you think was discriminatory?**

FOR EXAMPLE, I was denied an accommodation I needed to perform my job; I was fired because I was pregnant; I was laid off because of my age. Include dates.

Date: \_\_\_\_\_ Action: \_\_\_\_\_

Date: \_\_\_\_\_ Action: \_\_\_\_\_

Name of Person(s) Responsible: \_\_\_\_\_

**What reason(s), if any were you given for this negative job action(s) taken against you?**

Reason: \_\_\_\_\_

Who told you this? \_\_\_\_\_ His / Her Job Title: \_\_\_\_\_

**Describe who was in the same or similar situation as you and how they were treated.**

FOR EXAMPLE, who else applied for the same job that you did, who else had the same attendance record, or who else had the same performance appraisal? Also, if your complaint alleges race discrimination, provide the race of each person; if it alleges sex discrimination, provide the sex of each person.

**Who was treated BETTER than you?**

A. Full Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Race, Sex, National Origin, Color, Religion, Age, or Disability: \_\_\_\_\_

Description of treatment: \_\_\_\_\_

Date: \_\_\_\_\_

B. Full Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Race, Sex, National Origin, Color, Religion, Age, or Disability: \_\_\_\_\_

Description of treatment: \_\_\_\_\_

Date: \_\_\_\_\_

**Who was treated WORSE than you?**

Full Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Race, Sex, National Origin, Color, Religion, Age, or Disability: \_\_\_\_\_

Description of treatment: \_\_\_\_\_

**Who was treated the SAME as you?**

Full Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Race, Sex, National Origin, Color, Religion, Age, or Disability: \_\_\_\_\_

Description of treatment: \_\_\_\_\_

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**Are there any witnesses to any of the alleged discriminatory negative job actions taken against you? If yes, please tell us what they will say.**

A. Full Name: \_\_\_\_\_ Job Title: \_\_\_\_\_  
Address: \_\_\_\_\_ Home or Cell#: \_\_\_\_\_  
What will they tell us: \_\_\_\_\_

B. Full Name: \_\_\_\_\_ Job Title: \_\_\_\_\_  
Address: \_\_\_\_\_ Home or Cell#: \_\_\_\_\_  
What will they tell us: \_\_\_\_\_

**Have you already filed a charge on this matter with the EEOC?**

Yes  No Date you filed: \_\_\_\_\_ Charge Number: \_\_\_\_\_

**Have you filed a complaint on this matter with another agency?**

Yes Agency name: \_\_\_\_\_  
Date you filed: \_\_\_\_\_ Complaint Number: \_\_\_\_\_

No

**Have you sought help about this matter from a union, an attorney, or other source?**

Yes Organization name: \_\_\_\_\_  
Name of person you spoke with: \_\_\_\_\_ Date of Contact: \_\_\_\_\_  
Results, if any: \_\_\_\_\_

No

This form helps us determine if your situation is covered by the employment discrimination laws we enforce. You must file a charge of job discrimination within 90 days from the day you knew about the discrimination, or within 300 days from the day you knew about the discrimination if the employer is located in a place where a state or local government agency enforces laws similar to the EEOC's laws. If you would like to file a charge of discrimination immediately, you should contact the FEPO office listed in the cover letter or call **1-671-300-4544**

#### **Privacy Act Statement**

This form is covered by the Privacy Act of 1974: Public Law 93-579. Authority for requesting personal data and the uses thereof are: **1) FORM NUMBER / TITLE / DATE. EEOC INTAKE QUESTIONNAIRE**, Form 290 A.2, July 2016. **2) Authority.** 42 U.S.C. § 2000e-5 (b), 29 U.S.C. § 211, 29 U.S.C. § 626.42 U.S.C. § 12117(a) **3) PRINCIPAL PURPOSE.** The purpose of this form is to solicit information about claims of employment discrimination, determine whether the EEOC has jurisdiction over those claims, and provide charge counseling, if appropriate. **4) ROUTINE USES.** EEOC may disclose information from this form to other state, local and federal agencies as appropriate or necessary to carry out the Commission's functions, or if EEOC becomes aware of a civil or criminal law violation. EEOC may also disclose information to respondents in litigation, to congressional offices in response to inquiries from parties to the charge, to disciplinary committees investigating complaints against attorneys representing the parties to the charge, or to federal agencies inquiring about hiring or security clearance matters. **5) WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL FOR NOT PROVIDING INFORMATION.** Providing this information is voluntary but the failure to do so may hamper the Commission's assessment of your situation. It is not mandatory that this form be used to provide the requested information, EEOC Inquiry Questionnaire, Form 290A.2. Issued July 2016

**After completing this form, return it immediately to the Fair Employment Practice Office ("FEPO") office identified in the cover letter to this questionnaire, or to the office assistant if you are completing this Questionnaire in an FEPO office.**

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## Information about your job or the job you applied for

Date Hired: \_\_\_\_\_ Job Title at Hire: \_\_\_\_\_  
Pay Rate When Hired: \_\_\_\_\_ Last or Current Pay Rate: \_\_\_\_\_  
Job Title at Time of Alleged Discrimination: \_\_\_\_\_  
Date Your Employment Ended: \_\_\_\_\_ Select One:  Quit  Discharged  Other  
Name and Title of your Immediate Supervisor: \_\_\_\_\_  
Job Applications – What was the title of the job for which you applied: \_\_\_\_\_  
Date you applied: \_\_\_\_\_ Date you found out you were not hired: \_\_\_\_\_

## What is the (basis) for your claim of employment discrimination?

FOR EXAMPLE, if you feel that you were treated worse than someone else because of your race, check the box next to Race. If you feel you were treated worse for several reasons, such as your sex, religion, and national origin, check all that apply.

- |   |  |                                |                                     |  |
|---|--|--------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Race               | <input type="checkbox"/> National Origin                         | <input type="checkbox"/> Sex   | <input type="checkbox"/> Color      | <input type="checkbox"/> Genetic Information |
| <input type="checkbox"/> Religion           | <input type="checkbox"/> Retaliation                             | <input type="checkbox"/> Age   | <input type="checkbox"/> Disability | <input type="checkbox"/> Pregnancy           |
| <input type="checkbox"/> Sexual Orientation | <input type="checkbox"/> Gender Identity (including transgender) | <input type="checkbox"/> Other |                                     |  |

If you checked **Genetic Information**, please choose all that apply:

- Genetic Testing
- Family Medical History
- Genetic Services (genetic services mean genetic counseling, education or testing.)
- Breastfeeding (Guam Only) (Public Law 32-098: Mother and Child Act)

If you checked **Color, Religion or National Origin**, please specify: \_\_\_\_\_

If you checked **Disability**, please check all that apply:

- You have a disability
- You had a disability in the past
- The organization regards you as if you had or have a disability
- You are closely related to or associated with a disabled person

The disability (condition) that you believe was the basis for the employer's alleged discrimination:

\_\_\_\_\_

Is your employer aware of your condition?  Yes  No If yes, how?

\_\_\_\_\_

Is your condition something that adversely affects you at work?  Yes  No If yes, how?

\_\_\_\_\_

If you checked **Retaliation** and were threatened with or received a negative job action because of any of the following reasons, please check all that apply:

- You filed a charge of job discrimination or contacted a government agency to complain about job discrimination
- You helped or were a witness in someone else's complaint about job discrimination;
- Or you complained to your employer about job discrimination.
- You requested an accommodation for a disability

If you checked **Other**, describe the reason (basis) for discrimination:

\_\_\_\_\_

\_\_\_\_\_

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