FAIR EMPLOYMENT PRACTICE OFFICE
INQUIRY QUESTIONNAIRE

414 West Soledad Avenue
GCIC Building, Suite 401
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 <u>same or similar situation as you</u> 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 <u>BETTER</u> 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 <u>WORSE</u> than you?

Full Name: _____ Job Title: _____
Race, Sex, National Origin, Color, Religion, Age, or Disability: _____
Description of treatment: _____

Who was treated the <u>SAME</u> as you?

Full Name: _____ Job Title: _____
Race, Sex, National Origin, Color, Religion, Age, or Disability: _____
Description of treatment: _____

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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.

☐Race ☐National Origin ☐Sex ☐Color ☐Genetic Information
☐Religion ☐Retaliation ☐Age ☐Disability ☐Pregnancy
☐Sexual Orientation ☐Gender Identity (including transgender) ☐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 <u>all</u> 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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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

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