

APPEAL FORM

From: _____ Complainant Accused
To: _____, State District Superintendent
Date of Incident: _____

Discrimination on the basis of:	<input type="checkbox"/> Race / Color	<input type="checkbox"/> National / Ethnic Origin	<input type="checkbox"/> Age
	<input type="checkbox"/> Sex	<input type="checkbox"/> Sexual Orientation	<input type="checkbox"/> Sexual Harassment
	<input type="checkbox"/> Gender Identity	<input type="checkbox"/> Disability	<input type="checkbox"/> Other:
	<input type="checkbox"/> Religion	<input type="checkbox"/> Creed	

Reason for dissatisfaction with the decision of the Affirmative Action Officer:

Requested Relief:

Kindly submit a copy of your initial Written Statement and a copy of the Affirmative Action Officer's letter with your Appeal Form.

Print Name: _____

Signature: _____

Date

DISTRICT POLICY AND STATE LAW PROHIBITS RETALIATION AGAINST ALL PARTICIPANTS.