



**WASHINGTON STATE HUMAN RIGHTS COMMISSION  
PUBLIC ACCOMMODATION, CREDIT & INSURANCE  
COMPLAINT QUESTIONNAIRE**

Local: 360.753.6770 | Toll Free: 1.800.233.3247  
Fax: 360.586.2282

FOR OFFICIAL USE ONLY

The Washington State Human Rights Commission (WSHRC) is a neutral, fact-finding law enforcement agency. It does not act as an advocate for any party during an investigation, but advocates for the law in the interest of preventing and eliminating discrimination.

**Answer all questions completely and please write clearly.  
INCOMPLETE QUESTIONNAIRES WILL NOT BE ACCEPTED**

If you require assistance in completing this form as a reasonable accommodation, please contact us at 1.800.233.3247 or at [frontdesk@hum.wa.gov](mailto:frontdesk@hum.wa.gov)

**After completing this Complaint Questionnaire, return it immediately to:**

**711 S. Capitol Way, Suite 402 PO BOX 42490  
Olympia, WA 98504-2490**

**or via e-mail at**

**[frontdesk@hum.wa.gov](mailto:frontdesk@hum.wa.gov)**

CHECK HERE IF YOU HAVE ALREADY FILED A COMPLAINT WITH ANOTHER AGENCY

If yes, agency name:

Date you filed:  Complaint Number:

What is the status of your other complaint?

**PERSONAL INFORMATION**

*KEEPING YOUR CONTACT INFORMATION CURRENT*

It is your obligation to cooperate with the investigation, including providing the Commission with notice of any change of address, phone number, or any prolonged absence from your current address or phone. If you fail to notify the Commission of this, your inquiry or complaint may be closed administratively due to our inability to locate you, or may be closed based upon the evidence at the time.

First Name:  MI:  Last Name:

Home Phone: (  )  Cell Phone: (  )

Email:  Sex/Gender:

Mailing Address:  Apt/Unit#:

City:  County:  State:  Zip Code:

What is the best way to reach you?

What are the best days and times to reach you?

**I BELIEVE I WAS DISCRIMINATED AGAINST BY THE FOLLOWING ORGANIZATIONS  
(CHECK ALL THAT APPLY):**

- Public Accommodation       Creditor       Insurer

**WHO DO YOU THINK DISCRIMINATED AGAINST YOU?**

Organization Name:

Address:

City:  County:  State:  Zip Code:

Type of Business:  Phone: (  )

What is your relationship with the business? (customer, patient, student, etc.)

**WHAT IS THE REASON, OR BASIS, FOR YOUR CLAIM OF DISCRIMINATION?**

FOR EXAMPLE: If you feel that you were treated unfairly because of race, you should check the box next to "Race". If you feel you were treated unfairly for several reasons, such as your gender, religion, and/or national origin, you should check all that apply.

If you complained about discrimination, participated in someone else's complaint, or filed a charge of discrimination, and a negative action was take, you should check the box next to "Retaliation".

National Origin -   Sexual Orientation / Gender Identity

Race -   Sex (Including pregnancy)

Color (skin shade) -   HIV/Hep C Status

Creed/Religion -   Citizenship / Immigration Status

Veteran Status (Public Accommodation and Credit Only)  Retaliation

Breast Feeding (Public Accommodation Only)

Marital Status (Credit & Insurance Only)

Disability - Check all that apply:

I have a disability.

I had a disability in the past.

The disability involved:

Does this disability prevent or limit you from doing anything? (i.e. walking, breathing, etc.)

Use of a trained dog guide or service animal by a person with a disability

I have a service animal.

What type of service animal and what service does it provide?

None of the above - list reason:

**WHAT HAPPENED TO YOU THAT YOU THINK WAS DISCRIMINATORY  
AND WHEN DID IT HAPPEN?**

Date:  Action:

Name/Title of Person(s) Responsible:

Date:  Action:

Name/Title of Person(s) Responsible:

**WHAT REASON(S) WERE YOU GIVEN FOR THIS ACTION?**

Reason(s):

Who told you this?  Their Job Position (if known):

**WAS ANOTHER PERSON IN THE SAME OR SIMILAR SITUATION TREATED  
THE SAME, BETTER, OR WORSE THAN YOU?**

*WHO WAS TREATED BETTER THAN YOU?*

Name:  Relationship:

Email:  Phone: (  )

How were they treated better?

Date:

*WHO WAS TREATED WORSE THAN YOU?*

Name:  Relationship:

Email:  Phone: (  )

How were they treated worse?

Date:

*WHO WAS TREATED THE SAME AS YOU?*

Name:  Relationship:

Email:  Phone: (  )

How were they treated the same?

Date:

**ARE THERE ANY WITNESSES TO ANY OF THE ACTIONS TAKEN AGAINST YOU?  
IF YES, PLEASE PROVIDE THEIR CONTACT INFORMATION  
AND TELL US WHAT THEY WILL SAY.**

**First Witness -**

Name:  Relationship:

Email:  Phone: (  )

What will they tell us?

**Second Witness -**

Name:  Relationship:

Email:  Phone: (  )

What will they tell us?

**HAVE YOU ALREADY FILED A CHARGE ON THIS MATTER WITH THE  
WASHINGTON STATE HUMAN RIGHTS COMMISSION?**

Yes  No If yes, when did you file?  Charge Number:

**DO YOU HAVE SOMEONE REPRESENTING YOU IN THIS MATTER?**

Yes  No If yes, what is their title? (i.e. attorney)

Name:  Date of Contact:

Address:  City:  State:  Zip Code:

Email:  Phone: (  )

**WHO CAN WE CONTACT IF WE ARE UNABLE TO REACH YOU?**

Name:  Relationship:

Address:  City:  State:  Zip Code:

Email:  Phone: (  )

Additional Comments:

*PUBLIC DISCLOSURE*

Any information and documents that you submit to the Commission are subject to public records laws and will be available to anyone who requests them.

**This includes medical and other types of private records.**

Therefore, it is in your best interests not to submit anything unless requested by your investigator.

The Washington State Human Rights Commission has no jurisdiction over certain services or entities, including, but not limited to:

police actions; the decisions of courts, city, and county commissioners, or other administrative or licensing agencies; Internet sites; the denial of public benefits; child support; court ordered visitation; prison and jails and their inmate programs; child or adult protective services; Native American tribes; and the federal government.

The agency has no jurisdiction over claims in which the last date of harm occurred more than 6 months ago, or over issues that did not occur in Washington.

Complaints that do not meet jurisdictional requirements, including complaints where the allegations of the complaint, if true, show no basis for commission action after preliminary evaluation, will not be accepted for investigation.

I want to file a charge of discrimination. I authorize the WSHRC to look into the discrimination I described in this Complaint Questionnaire. I understand that if my claim does not meet jurisdictional requirements, it will not be accepted for investigation and that there will be no follow-up on this inquiry from the WSHRC.

Please review the form BEFORE digitally signing. Once digitally signed, you will not be able to edit the document. If you're having difficulty creating or signing digitally, a physical signature can be used.

Signature:

Date:

**ANY DECISION MADE BY THE COMMISSION DOES NOT PRECLUDE YOUR RIGHT TO FILE A CIVIL ACTION IN A COURT OF COMPETENT JURISDICTION, PURSUANT TO RCW 49.60.030.**