



PUBLIC ACCOMMODATION DISCRIMINATION INTAKE QUESTIONNAIRE
LINCOLN COMMISSION ON HUMAN RIGHTS
440 South 8th Street, Suite 101
Lincoln, NE 68508

PLEASE PRINT

Name: (First, Middle, Last)		Date of Birth:	Age:	
Address: (Number and Street)	Apt No:	City:	State:	Zip Code:
Telephone Numbers and Area Codes:		Email Address:		
Home:				
Work:	Ext:	Preferred Time:	Preferred Days:	
Name of Person to Contact If you Cannot be Reached:			Telephone Number:	

BASIS OF DISCRIMINATION: (CHECK ONE OR MORE OF THE FOLLOWING)

<input type="checkbox"/> Race: (Specify) _____	<input type="checkbox"/> Color: (Specify) _____	<input type="checkbox"/> Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> National Origin: (Specify) _____	<input type="checkbox"/> Religion: (Specify) _____	<input type="checkbox"/> Other: (Specify) _____
<input type="checkbox"/> Disability: (Specify) _____	<input type="checkbox"/> Marital Status: (Specify) _____	

THE ACT(S) OF DISCRIMINATION WERE RELATED TO: (Check ALL that apply)

<input type="checkbox"/> Denial of Service	<input type="checkbox"/> Denial of Accommodations	<input type="checkbox"/> Denial of Credit
<input type="checkbox"/> Other: (Explain) _____		

1. RESPONDENT INFORMATION: (Please Use "N/A" if information is not available or unknown at this time)

Name of Business or Service Provider:	Telephone Number:		
Address: (Number and Street)	City:	State:	Zip Code:
Name of Person who Discriminated:	Title:	Telephone Number:	

LIST THE NAMES AND PHONE NUMBERS OF WITNESSES YOU FEEL COULD PROVIDE EVIDENCE IN YOUR SUPPORT:

(1) Name of Witness:	Telephone number:		
Address:	City:	State:	Zip Code:
(2) Name of Witness:	Telephone number:		
Address:	City:	State:	Zip Code:
(3) Name of Witness:	Telephone number:		
Address:	City:	State:	Zip Code:
(4) Name of Witness:	Telephone number:		
Address:	City:	State:	Zip Code:

BRIEFLY EXPLAIN how and/or why you feel discriminated against (how you were treated differently from others), by whom, when, and where. Be sure to indicate all dates (month, day, year) and names as accurately as possible. **If filing on the basis of disability, please provide appropriate medical documentation.**

IF MORE SPACE IS NEEDED, PLEASE ATTACH ADDITIONAL SHEETS

What Reasons, if any, were you given for the action you are reporting?

Who gave you these reasons?

OTHER ACTIONS

Have you filed with the United States Department of Justice or any other agency or group? Yes No

Address: (Number and Street)

Name of Agency:

Telephone number:

City:

State:

Zip Code:

Name of person who assisted You:

What has this person done for You on this problem?

Do you have an attorney?

Yes No

Name of attorney:

Telephone Number:

Address:

City:

State:

Zip Code:

REMEDIES YOU ARE SEEKING FOR RELIEF:

YOU LEARNED ABOUT/WAS REFERRED TO THE LINCOLN COMMISSION ON HUMAN RIGHTS BY: