



**DELAWARE DEPARTMENT OF LABOR
DIVISION OF INDUSTRIAL AFFAIRS
OFFICE OF ANTI-DISCRIMINATION**

Statute of Limitations

A charge of employment discrimination must be filed within the time limits imposed by law. Under Delaware (and federal) law, a charge of employment discrimination must be filed within **300 days** of the most recent negative employment action in order for state statutes to apply.

***If you have previously filed with the EEOC regarding this claim of discrimination, please provide the Case File number(s) to avoid delays in processing your claim(s).** _____

****If you have retained an attorney, please have them provide us with a Letter of Representation.**

Two Step Charge Filing Process

Step 1- Complete this Questionnaire and respond to any follow-up questions by phone or email from the intake officer.

Step 2- Review the Charge of Discrimination and sign the official Charge of Discrimination Form before a Notary.

Upon receipt of the completed Intake Questionnaire, you will be notified of the date and time of your Notarizing Appointment via email and/or regular mail.

The completed Intake Questionnaire and any supporting documentation may be submitted by mail, fax, email or in-person.

MAIL Delaware Department of Labor
Office of Anti-Discrimination
4425 N. Market Street, 3rd Floor
Wilmington, DE. 19802

EMAIL DOL_Antidiscrimination@delaware.gov

FAX (302) 622-4105

IN PERSON	4425 N. Market St Wilmington, DE. 19802	Christiana Building 252 Chapman Rd, 2nd FL Newark, DE. 19702	655 Bay Rd. Ste. 2H Dover, DE. 19901	8-B Georgetown Plaza Ste. 2 Georgetown, De. 19947
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Thank you for contacting the Delaware Department of Labor, Office of Anti-Discrimination. Our office is a **neutral enforcement office**, responsible for enforcing the anti-discrimination laws¹ and, as such, **is unable to provide legal advice or guidance.**

For additional information regarding the laws enforced by the Office of Anti-Discrimination and the charge filing process, please refer to our website at www.labor.delaware.gov/antidiscrimination

¹ Title 19, Chapter 7 of the Delaware Code

INTAKE QUESTIONNAIRE

**~ATTACH A CLEAR COPY OF YOUR GOVERNMENT ISSUED PHOTO ID~
~TO EXPEDITE THE PROCESSING OF YOUR CLAIM~**

PLEASE NOTE THAT SUBMISSION OF THE INTAKE QUESTIONNAIRE DOES NOT COMPLETE THE PROCESS OF FILING A CHARGE OF EMPLOYMENT DISCRIMINATION. Please complete all applicable sections of this form and return to the Delaware Department of Labor, Office of Anti-Discrimination.

PLEASE PRINT Answer all questions completely; attach additional pages if needed to complete your responses. If you do not know the answer to a question, answer by stating "Not Known." If a question is not applicable, write "N/A."

First Name	Middle Initial
Last Name	Suffix: Jr., Sr., etc.
Salutation – Circle One: Mr. Miss, Ms., Mrs., Dr. Hon.	Pronoun
Address Line 1	Address Line 2
Zip Code	Country
State	Email
Home Phone Area Code () _____	Cell Phone Area Code () _____
Work Phone Area Code () _____	Gender Born as: <input type="checkbox"/> Male <input type="checkbox"/> Female. Identifies as: <input type="checkbox"/> Male <input type="checkbox"/> Female
Work Extension	Fax
Language	Date of Birth
Do you require a language interpreter?	Do you require sign language interpretation?
<p>ETHNICITY Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ELECTED RACE Please choose all that may apply.</p> <p><input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Bi-Racial <input type="checkbox"/> multi-Racial</p>	<p>NATIONAL ORIGIN</p> <p><input type="checkbox"/> African Origin Group <input type="checkbox"/> American/Other Origin Group <input type="checkbox"/> Asian Origin Group <input type="checkbox"/> Caribbean Origin Group <input type="checkbox"/> European Origin Group <input type="checkbox"/> Hispanic/Latino Origin Group <input type="checkbox"/> Middle Eastern Origin Group</p>

Please indicate which office location you find most convenient:

Wilmington
 Newark
 Dover
 Georgetown

Name of person we can contact if we are unable to reach you:

First Name	Last Name
Address Line 1	Address Line 2
Zip Code	Country
State	Email
Home Phone Area Code () _____	Cell Phone Area Code () _____

EMPLOYMENT INFORMATION

Please note, this office does not have jurisdiction over worksites outside of Delaware or any Federal Facilities (Post Office, Veterans etc.) We can refer you to the EEOC or the state where the worksite exists.

Name of Employer who is responsible for your payroll/compensation: _____

Name of the Employer (not the person) that you believe violated your civil employment rights. I believe that I was discriminated against by the following Employer(s) Check those that apply and provide the Delaware location where you work(ed) or applied.

Employer Union Staffing/Employment Agency Other (Please Specify)

Employer/Union/Staffing Agency information.

*Name(s): _____

*Address: _____

*City: _____ County: _____ *State: _____ *Zip: _____

Phone: () _____

Human Resources Director or Owner Name: _____

Phone: () _____

Client/Assignment Location in Delaware Where You Experienced Discrimination:

*Name(s): _____

*Address: _____

*City: _____ County: _____ *State: _____ *Zip: _____ Phone: _____

() _____

Human Resources Director or Owner Name: _____

Phone: () _____

Number of Employees in the Organization in Delaware: (please check one)

Less than 4 4-14 15 or more Unknown

*Date Hired: _____ *Job Title at Hire: _____

*Job Title at Time of Alleged Discrimination: _____

Employment Status (please check one): Still employed Discharged Resigned

Date Resigned/Discharged: _____

1. What do you believe is/was the Employer's motivating factor for taking the negative employment action(s) against you? Check the box(es) below that apply.

<input type="checkbox"/> Race	<input type="checkbox"/> National Origin (country of origin or ancestry)	
<input type="checkbox"/> Color (typically a difference in skin shade within the same perceived race). Specify Color:		
<input type="checkbox"/> Age (40+ Years)	<input type="checkbox"/> Sex	<input type="checkbox"/> Victim of Domestic Violence or Stalking
<input type="checkbox"/> Disability	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Genetic Information
<input type="checkbox"/> Sexual Orientation	<input type="checkbox"/> Religion - Specify:	<input type="checkbox"/> Reproductive Health Decisions
<input type="checkbox"/> Gender Identity	<input type="checkbox"/> Protected Hair Style(s)	<input type="checkbox"/> Family Care Responsibilities
<input type="checkbox"/> Marital Status	<input type="checkbox"/> Housing Status	
<input type="checkbox"/> Membership in Volunteer Emergency Responder Organization		

If you checked genetic information, please indicate whether you are alleging discrimination on the basis of

genetic testing, family medical history, or genetic services/education/counseling.

Did you initiate a complaint of employment discrimination to management; oppose a discriminatory practice(s) or engage in protected activity which is covered by any anti-discrimination laws?

Yes or No

2. What material adverse employment action did you experience?

Discipline Suspension Discharge Transfer Demotion Harassment Failure to Promote

Failure to Hire Failure to Accommodate (for disability, pregnancy, or religion ONLY) Other _____

Please provide the date(s) of the alleged adverse action(s) and the name(s) and title(s) of the person(s) responsible. **Please attach pages if needed.** (Example: 10/01/2023 – discharged by Mr. John Doe, Office Manager); at least one date must be provided.

A. Date: _____ Action: _____

Name and Title of Person(s) Responsible: _____

B. Date: _____ Action: _____

Why do you believe these actions are/were discriminatory? Please attach additional pages if needed.

3. **If applicable, what reason(s) were given to you for the acts you consider discriminatory?** By whom? His or her job title:

4. **Were you harassed on the basis of any protected classes listed above in question #1, i.e., race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, age (40 or older), disability and genetic information (including family medical history), etc.** Yes No
Was/is the person(s) responsible a Supervisor Co-worker Other – Specify: _____

Did you notify the employer of the unwelcome conduct? Yes No

If "Yes," when did you complain? _____ Did you complain verbally or in writing? _____

To whom did you complain? _____

How did your employer respond to your harassment complaint?

5. **If you are alleging that your material adverse employment action(s) was based on a disability, please check all that may apply:**

- I have an actual disability
- I have a record of a disability
- I am regarded as having a disability

6. **How was your disability a motivating factor in the Employer's decision to take the negative employment action(s) against you?**

7. **Did you request a reasonable accommodation?** Yes No

If "Yes," when did you ask? _____ Did you ask verbally or in writing? _____

Who did you ask? _____

Describe the changes or assistance that you requested:

8. **Did your employer accommodate your request?** Yes No If "No," why not?

9. Please provide a comparator that was treated more favorably than you were.

Of the persons in the same or similar situation as you, who was treated *better* than you?

A. _____

B. _____

10. Are there any witnesses to the alleged discriminatory incidents? If yes, please identify them below and tell us what they will say. For each entry, please include the Full Name, Job Title, Address and Telephone Number.

A. _____

B. _____

C. _____

11. What do you expect to achieve by filing this employment discrimination claim? Job reinstatement, compensation for lost wages, etc.

Date and Signature are required. If you do not date and sign, it will be returned to you for completion.

DATE

SIGNATURE

