Code: 418.2

EQUAL EMPLOYMENT OPPORTUNITY AFFIRMATIVE ACTION
AMERICANS WITH DISABILITIES ACT COMPLAINT FORM
Council Bluffs Community School District
300 W. Broadway, Ste. 1600
Council Bluffs, IA 51503

Name of Complainant: _____

Address: _____

_____ Phone: _____

Charge of Discrimination Based on [check appropriate area(s)]:

☐ Age ☐ Color ☐ Creed ☐ Gender Identity ☐ Mental Disability
☐ National Origin ☐ Physical Disability ☐ Race ☐ Religion ☐ Sex
☐ Sexual Orientation ☐ Other _____

Date that alleged violation occurred or began: _____

Complaint (Please write a brief statement of the complaint. Use back side or attach additional sheets if necessary): _____

_____

Complainant's Signature: _____

Date: _____

Date received by Complaint Officer: _____

If complaint is being filed by a representative of the complainant, sign here and state relationship to complainant:

Signature of Representative: _____

Relationship to complainant: _____

Please return completed form to the Council Bluffs Community School District Complaint Officer, Director of Compliance, 300 W. Broadway, Omni Business Center, Ste 1600, Council Bluffs, Iowa, 51503.

Approved: June 10, 1993 Reviewed: March 25, 2002 Revised: February 24, 2004
May 27, 2008
March 26, 2013
October 14, 2014
June 23, 2015
June 23, 2020