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 ☐ Mental Disability ☐ Sexual Orientation ☐ Religion ☐ Sex

☐ National Origin ☐ Physical Disability ☐ Race ☐ 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, Chief Legal and Human Resources Officer, 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
June 25, 2025