Town of Kearny
Department of Public Health • Walter J. Nicol Health Center
645 Kearny Avenue, Kearny, NJ 07032
Phone: 201-997-0600 • Fax: 201-997-9703
www.kearnynj.org

TITLE VI COMPLAINT FORM

Section I:			
Name:			
Address:		**Email address:**	
Telephone (Home):		**Telephone (Work):**	
Accessible Format Requirements? (check all that apply)	☐ **Large Print**	☐ **Audio Tape**	
	☐ **TDD**	☐ **Other**	
Section II:			
Are you filing this complaint on your own behalf?		Yes*	No
*If you answered "yes" to this question, go to Section III.			
If not, please supply the name and relationship of the person for whom you are complaining:			
Please explain why you have filed for a third party:			
Please confirm that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party.		Yes	No
Section III:			
I believe the discrimination I experienced was based on (check all that apply): ☐ Race ☐ Color ☐ National Origin			
Date of Alleged Discrimination (Month, Day, Year): _____			
Explain as clearly as possible what happened and why you believe you were discriminated against. Describe all persons who were involved. Include the name and contact information of the person(s) who discriminated against you (if known) as well as names and contact information of any witnesses. If more space is needed, then please use the back of this form.			
Section IV:			
Have you previously filed a Title VI complaint with this agency?		Yes	No
Section V:			
Have you filed this complaint with any other Federal, State, or local agency, or with any Federal or State court? ☐ Yes ☐ No			
If yes, check all that apply: ☐ Federal Agency ☐ Federal Court ☐ State Agency ☐ State Court ☐ Local Agency			
Please provide information about a contact person at the agency/court where the complaint was filed.			
Name:		**Title:**	
Agency:			
Address:		**Telephone:**	
Section VI:			
Name of agency complaint is against:		**Contact Person:**	
Title:		**Telephone:**	

You may attach any written materials or other information that you think is relevant to your complaint.
Complainant's signature and date required below:

_____ _____
Signature Date

Please submit this form in person at the address below, or mail this form to:
Health Officer
Kearny Health Department
645 Kearny Avenue
Kearny, NJ 07032