DISCRIMINATION COMPLAINT FORM

Name	Phone	Name of Person(s) That Discriminated Against You	
Address (Street No., P.O. Box, Etc.)		Location	Position of Person (If Known)
City	State Zip	City	State Zip
Discrimination Because of: ☐ Race/Color ☐ Sex ☐ Disability ☐ Age ☐ National Origin* ☐ Retaliation ☐ Religion		Date(s) of Alleged Incident(s)	

Explain as briefly and clearly as possible what happened and how you were discriminated against. Indicate who was involved. Be sure to include how other persons were treated differently than you. Also, attach any written material pertaining to your case.

Signature	Date

Please submit this form to PhilaPort's Civil Rights Coordinator.

	MAIL	**EMAIL**	
	PhilaPort Civil Rights Coordinator 3460 N. Delaware Ave, 2ND Floor Philadelphia, PA 19134	CRComplaint@philaport.com	