



You may use this form to file a complaint with the South Carolina Department of Public Health (DPH) if you believe that you have been discriminated against based on age, disability, veteran status, race, color, sex, pregnancy, religion, genetic information, national origin, gender identity, sexual orientation, denial of interpretation services, and/or denial of translation services. You do not have to use this form to file a complaint. You may submit a complaint in writing to any DPH local office, or by mail to the DPH Compliance Office, 2100 Bull Street, Columbia, SC 29201, or by email to [compliance@dph.sc.gov](mailto:compliance@dph.sc.gov), or by telephone at 1-888-843-3718. If you choose to submit your complaint via letter, email, or telephone, please provide all the information requested in this form. You may submit your complaint anonymously; however, DPH will be unable to contact you for further information or to inform you of the outcome of your complaint. Please type or print all information clearly, and use additional pages if more space is needed.

**1. Name of person filing complaint:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

**2. Name of person discriminated against (if different from person filing complaint):**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**3. Location of incident:**

Office: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Program/Service Area: \_\_\_\_\_

**4. Date(s) of Incident:** \_\_\_\_\_

**5. Name(s) of employee(s) involved in incident (if known/applicable):**

\_\_\_\_\_  
\_\_\_\_\_

**6. Basis of discrimination allegation (mark all that apply):**

Age

Disability

Race

Color

Gender Identity

Religion

Denial of Interpretation  
Services

Genetic Information

Sex

Denial of Translation  
Services

National Origin

Sexual Orientation

Pregnancy

Veteran Status

**7. Please provide a brief description of the incident:**

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

# Instruction for Completing Discrimination Complaint Form

2780-ENG-DPH

**Purpose:**

Meet federal guidelines and provide a way for members of the public to file discrimination complaints with the Agency.

**Audience:**

Members of the Public

The instructions are included on the form since it is intended for public use.

**Office Mechanics:**

The form should be retained for 6 years following resolution of the complaint under the Compliance Office Files retention schedule (17208).