



**New York State  
Department of Transportation  
Complaint of Discrimination Form**

Name   
Address  City  Zip   
Telephone Home  Work  Cell

**Basis of Complaint**

Race  National Origin   
Color  Age   
Sex  Disability

**Type of Complaint**

Program  Service  Benefit  Activity

**Who allegedly discriminated against you?**

Name of Individual   
Address   
City   
Zip   
Telephone

**If an organization, what is its name?**

Name of Organization   
Name of Contact   
Address   
City   
Zip   
Telephone

**How were you discriminated against?**

**Where did the alleged discrimination occur?**

**Date(s) and time(s) discrimination occurred?**

First Time	
Second Time	
Third Time	

**Were there any other witnesses to the discrimination?**

Name	Title	Work Phone	Home Phone

**What can the Department do to resolve the complaint?**

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**Have you filed your complaint with anyone else?**      Yes       No

Who	
When	
Complaint number, if known	

**Do you have an Attorney in this matter?**      Yes       No

Attorney Name	
Address	
City	
Zip	
Telephone	
When did you acquire?	

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Mail to:**      **Title VI Coordinator**  
                  **Office of Civil Rights**  
                  **New York State Department of Transportation**  
                  **50 Wolf Road**  
                  **Albany, New York 12232**      or      **FAX (518) 485-5517**  
                  **Phone (518) 457-1129**      **Email: [OCR-TitleVI@dot.ny.gov](mailto:OCR-TitleVI@dot.ny.gov)**