Member Discrimination or Harassment
COMPLAINT QUESTIONNAIRE

If you have experienced Sexual Harassment, please file a report using sagaftrasafeplace.org

YOUR CONTACT INFORMATION: (Please Print)

I WISH TO REMAIN ANONYMOUS ☐

SAG-AFTRA NUMBER	LAST NAME	FIRST NAME	MID INT.	DATE COMPLETED		
				MONTH	DAY	YEAR

MAILING ADDRESS	APT. #	CITY	STATE	ZIP CODE

HOME NUMBER	BUSINESS NUMBER	CELL NUMBER

EMAIL ADDRESS

PERSON TO CONTACT IN THE EVENT I CANNOT BE REACHED OR HAVE MOVED	TELEPHONE NUMBER

INCIDENT(S) DESCRIPTION

I WISH TO REPORT:

WHEN DID THE INCIDENT OCCUR?	IS THE INCIDENT ONGOING?	I DO NOT KNOW THE NAME(S) OF THE INDIVIDUAL(S): ☐

LAST NAME	FIRST NAME	MID INT.	EMPLOYER/COMPANY	TITLE

MAILING ADDRESS	APT. #	CITY	STATE	ZIP CODE

TELEPHONE NUMBER

I ALSO WISH TO REPORT:

(NAME OF INDIVIDUAL, AGENCY, COMPANY OR OTHER)

LAST NAME	FIRST NAME	MID INT.	EMPLOYER/COMPANY	TITLE

MAILING ADDRESS	APT. #	CITY	STATE	ZIP CODE

TELEPHONE NUMBER

POSSIBLE WITNESSES

List the names, addresses and telephone numbers (if possible) of witnesses, co-workers or others who know or should know (reasonable proximity) of information that supports your claim(s). Explain what you think each witness will be able to tell us.

POSSIBLE WITNESS

LAST NAME	FIRST NAME	MID INT.	TITLE/RELATIONSHIP

TELEPHONE NUMBER	CAN PROVIDE INFORMATION REGARDING:

POSSIBLE WITNESS

LAST NAME	FIRST NAME	MID INT.	TITLE/RELATIONSHIP

TELEPHONE NUMBER	CAN PROVIDE INFORMATION REGARDING:

ADDITIONAL WITNESSES

Please list the name(s) of any additional witness and information that supports your claim(s) in the 'Factual Overview' section found on the last page of this form.

ADDITIONAL CONTACT

HAVE YOU RETAINED AN ATTORNEY REGARDING THIS PROBLEM?
IF YES, PLEASE LIST THE ATTORNEY'S CONTACT INFORMATION BELOW. ☐ YES ☐ NO

LAST NAME	FIRST NAME	MID INT.	TELEPHONE NUMBER

MAILING ADDRESS	APT.#	CITY	STATE	ZIP CODE

LAST NAME	FIRST NAME	MID INT.	TELEPHONE NUMBER

MAILING ADDRESS	APT. #	CITY	STATE	ZIP CODE

HAVE YOU FILED A COMPLAINT WITH EITHER THE UNITED STATES EQUAL EMPLOYMENT OPPORTUNITY COMMISSION (EEOC) OR YOUR STATE AGENCY (E.G. CALIFORNIA STATE'S DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING)? ☐ YES ☐ NO

I BELIEVE I WAS DISCRIMINATED AGAINST AND/OR HARASSED BECAUSE OF MY: (CHECK ALL THAT APPLY)

RACE	COLOR	RELIGION	SEX	NATIONAL ORIGIN	DISABILITY	GENETIC INFORMATION	OTHER
☐	☐	☐	☐	☐	☐	☐	☐

FACTUAL OVERVIEW

Please provide a detailed factual overview of what you saw or experienced. (Please use the back of this form and/or attach any additional sheets if necessary.)

PRINT NAME	SIGNATURE	DATE

Your signature represents that you consent to allow the SAG-AFTRA Equity & Inclusion Department to contact productions, casting agencies and witnesses as named in this complaint, on your behalf, and for the purposes of obtaining information to assist in advising you of the actions or options necessary to resolve your complaint.

Please be assured that SAG-AFTRA takes your complaint seriously and, if deemed appropriate, will take steps to immediately process your complaint. Your complaint will be held to the highest standards of confidentiality.

If you should have any questions about this form or the process, please contact SAG-AFTRA's Equity & Inclusion Department:
Los Angeles Office: (323) 549-6644
New York Office: (212) 827-1542
Email: diversity@sagaftra.org

SAG-AFTRA
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