Instructions for Filing a Discrimination Complaint

Washington State Department of Health
Civil Rights & ADA Program
P.O. Box 47890
Olympia, WA 98504-7890
Phone: (833) 428-3703
Email: civil.rights@doh.wa.gov

Improving access and equitable participation in DOH's services

The Washington State Department of Health (DOH) complies with all applicable federal and state laws, rules and regulations, and does not exclude people or treat them differently because of race, sex, color, national origin, language, religion, age, disability, gender identity, sexual orientation, veteran or military status, or other protected class.

DOH provides language access services and disability accommodations — at no cost — to all customers receiving services or doing business with DOH, including but not limited to:

- Interpreter services with a certified interpreter (in person or over the phone)
- Qualified sign language interpreters
- Translation of DOH documents in your preferred language
- Aids and reasonable accommodations

You can file a discrimination complaint if you believe DOH:

- Discriminated or retaliated against you because of your age, sex, race, color, national origin, language, religion, disability, gender identity, sexual orientation, veteran or military status, or other protected class
- Failed to provide language access services (interpretation, translation, etc.)
- Failed to provide reasonable accommodations for your disability

There are three ways to file a complaint with our Civil Rights Program:

1. Email the completed Discrimination Complaint Form to civil.rights@doh.wa.gov.
2. Print and mail completed Discrimination Complaint form to:

   Washington State Department of Health
   Civil Rights & ADA Program
   P.O. Box 47890
   Olympia, WA 98504-7890

3. Call (833) 428-3703 to file a complaint over the phone with our team.

You may *also* file your complaint with the following authorities:

- U.S. Department of Justice (www.justice.gov): 800-514-0301
- U.S. Department of Health and Human Services, Civil Rights (www.hhs.gov): 877-696-6775
- Washington State Office of the Attorney General (www.atg.wa.gov): 800-551-4636
- Washington State Human Rights Commission (www.hum.wa.gov): 800-233-3247

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RESET FORM

Your Information

Language preference (check one)

- ☐ English
- ☐ Español/Spanish
- ☐ ខ្មែរ/Cambodian
- ☐ 简体中文/Chinese Simplified
- ☐ 繁體中文/Chinese Traditional
- ☐ 한국어/Korean
- ☐ Русский/Russian
- ☐ Soomaali/Somali
- ☐ Tiếng Việt /Vietnamese
- ☐ Other language - please provide:

Disability Accomodations (optional)			
First name	Last name		
Address			
City	State	ZIP Code	Country
Email Address		Phone Number	
Name of Representative/Attorney (optional)	Representative/Attorney Contact Information		

If your address or phone number changes after you submit a complaint, please let us know right away.

Discrimination Complaint Form

Complaint Details

Type of complaint (check all that apply)	When did this happen? (mm/dd/yyyy)
☐ Language access ☐ Discrimination ☐ Lack of accommodation ☐ Retaliation ☐ Harassment ☐ Sexual Harassment	

On what basis do you think discrimination occurred?

☐ Race or ethnicity ☐ Skin Color ☐ National Origin ☐ Age
☐ Language ☐ Religion ☐ Sexual Orientation ☐ Disability
☐ Gender Identity ☐ Sex ☐ Veteran/Military Status
☐ Other - please provide:

Explain what happened. Attach additional pages if needed. Please write your name on each attached page.

Have you filed a complaint about this before?	If "yes", with whom and when? (mm/dd/yyyy)
☐ Yes ☐ No	

Privacy Notice: Information collected via this form is considered public information and may be released for inspection and copying by members of the public if requested. If a public request is received, this form will be released as required by the Public Records Act (RCW 42.56). Your personal information — including your name, address, email, phone number, and any medical records provided — will be removed before any records are released. The details of the complaint itself will be released.

Who is the complaint about (if known)?
Attach additional pages, if needed. Please write your name on each attached page.

Name the person you believe discriminated against you	Title	Phone number
Name the person you believe discriminated against you	Title	Phone number
Name the person you believe discriminated against you	Title	Phone number
Name of witness to the incident		Phone number
Name of witness to the incident		Phone number

Signature **Date**

For more information: Call (833) 428-3703 or email us at civil.rights@doh.wa.gov.

Washington State Department of HEALTH

DOH 750-202 September 2024

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.