Title VI Complaint Form

Use this form to file any Title VI Complaint with the _______________________

Section I:
Name:
Address:
Telephone (Home): Telephone (Work):
Electronic Mail Address:

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<thead>
<tr>
<th>Accessible Format Requirements?</th>
<th>Large Print</th>
<th>Audio Tape</th>
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<td>TDD</td>
<td>Other</td>
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Section II:
Are you filing this complaint on your own behalf?  Yes*  No
*If you answered "yes" to this question, go to Section III.
If not, please supply the name and relationship of the person for whom you are complaining:

Please explain why you have filed for a third party:

Please confirm that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party:  Yes  No

Section III:
I believe the discrimination I experienced was based on (check all that apply):
[ ] Race  [ ] Color  [ ] National Origin
Date of Alleged Discrimination (Month, Day, Year):

Explain as clearly as possible what happened and why you believe you were discriminated against. Describe all persons who were involved. Include the name and contact information of the person(s) who discriminated against you (if known) as well as names and contact information of any witnesses. If more space is needed, please use the back of this form.

Section IV
Have you previously filed a Title VI complaint with this agency?  Yes  No

Section V
Have you filed this complaint with any other Tribal, Federal, State, or local agency, or with any Tribal, Federal or State court?  [ ] Yes  [ ] No
If yes, check all that apply:

[ ] Tribal Court ____________________  [ ] Tribal Agency ____________________
[ ] Federal Agency ___________________  [ ] State Agency ____________________
[ ] Federal Court ____________________  [ ] Local Agency ____________________
[ ] State Court ______________________

Please provide information about a contact person at the agency/court where the complaint was filed.

Name:
Title:
Agency:
Address:
Telephone:

**Section VI**
Name of agency complaint is against:
Contact person:
Title:
Telephone number:

You may attach any written materials or other information that you think is relevant to your complaint.

Signature and date required below

______________________________   ______________________
Signature  Date

Please submit this form in person at the address below, or mail this form to: Coquille Indian Tribe
Community Health
Center 600 Miluk Drive
Coos Bay, OR 97420
Attention: Assistant Health Administrator