DISCRIMINATION COMPLAINT FORM

<table>
<tr><td>Your Name</td><td>Phone #</td><td>Name of Person(s) that disciminated againt you</td></tr>
<tr><td colspan="2">Address (Street No., P.O. Box, Etc.)</td><td>Location and Position of Person (If Known)</td></tr>
<tr><td colspan="2">City, State, Zip</td><td>City, State, Zip</td></tr>
<tr><td colspan="2">Discrimination Because of
☐ Race/Color ☐ Sex ☐ Disability
☐ Age ☐ National Origin ☐ Retalliation
☐ Religion</td><td>Date(s) of Alleged Incident(s)</td></tr>
<tr><td colspan="3">Explain as briefly and clearly as possible what happened and how you were discriminated against. Indicate who was involved. Be sure to include how other persons were treated differently than you. Also, attach any written material pertaining to your case.</td></tr>
<tr><td colspan="2">Signature</td><td>Date</td></tr>
<tr><td colspan="2">HBFAAA
240 Wood St., P.O. Box 46
Bedford, PA 15522
Phone (814) 623-8148
Fax (814) 623-5929</td><td>Federal Motor Carrier Safety Administration
1200 New Jersey Avenue, SE
Washington, DC 20590
Attn: Title VI or ADA Program Coordinator</td></tr>
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