

# Intake/Referral Form

## Statement Concerning Confidentiality

Pursuant to Tennessee Code Annotated § 10-7-503(a)(2)(A), "all state . . . records . . . shall at all times, during business hours, be open for personal inspection by any citizen of Tennessee, and those in charge of such records shall not refuse such right of inspection to any citizen, unless otherwise provided by state law." Accordingly, the State cannot and does not guarantee the confidentiality of this document or any notes, files, reports, or other documents, whether created by the State or received from the complainant, accused, or witnesses.

NAME OF COMPLAINANT OR PERSON REPORTING EVENT:

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EMAIL/TELEPHONE NUMBERS OF COMPLAINANT OR PERSON REPORTING EVENT:

EMAIL: \_\_\_\_\_

WORK: \_\_\_\_\_

PREFERRED: \_\_\_\_\_

NAME OF AGENCY AND DIVISION INVOLVED:

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NAME OF ACCUSED PERSON(S):

RELATIONSHIP OF ALLEGED ACCUSED TO YOU (I.E. DIRECT SUPERVISOR, CO-WORKER):

DATE OF EARLIEST OCCURRENCE OF EVENTS?

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DATE OF LATEST OCCURRENCE OF EVENTS?

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WHAT IS THE BASIS FOR YOUR COMPLAINT? (I.E. ABUSIVE CONDUCT IN THE WORKPLACE, DISCRIMINATION, HARASSMENT, RETALIATION, WORKPLACE VIOLENCE, ETC.)

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EXPLAIN AS CLEARLY AS POSSIBLE WHAT HAPPENED, INCLUDING WHO DID WHAT, WHERE IT OCCURRED, WHO WAS INVOLVED, ETC. PLEASE ATTACH ADDITIONAL PAGES IF NECESSARY.

EXPLAIN WHY YOU BELIEVE THESE EVENTS OCCURRED:

WERE OTHER EMPLOYEES TREATED DIFFERENTLY THAN YOU? IF YES, DESCRIBE HOW:

IF YOU ANSWERED YES TO THE PREVIOUS QUESTION, PLEASE PROVIDE THE NAMES OF THE EMPLOYEES WHO WERE TREATED DIFFERENTLY:

PLEASE LIST BELOW ANY PERSONS (WITNESSES, FELLOW EMPLOYEES, SUPERVISORS, OTHERS) WHO MAY HAVE ADDITIONAL INFORMATION TO SUPPORT OR CLARIFY THIS COMPLAINT. EXPLAIN WHAT INFORMATION EACH CAN PROVIDE.

WHAT EXPLANATION DO YOU THINK THE AGENCY OR ACCUSED WILL GIVE AS TO WHY YOU WERE TREATED IN THIS MANNER?

PLEASE IDENTIFY ANY OTHER INFORMATION (INCLUDING DOCUMENTARY EVIDENCE SUCH AS DIARIES, JOURNALS, RECORDINGS, EMAILS, VOICEMAILS, CORRESPONDENCE, ETC.) THAT YOU THINK IS RELEVANT TO THIS MATTER.

WHAT DO YOU WANT TO HAPPEN AS A RESULT OF THIS COMPLAINT?

WOULD YOU BE OPEN TO PARTICIPATING IN MEDIATION WITH THE ACCUSED ABOUT THE INCIDENT(S)?

SIGNATURE OF COMPLAINANT: \_\_\_\_\_

DATE: \_\_\_\_\_

IF COMPLETED BY SUPERVISOR OR AGENT OF STATE AS A RESULT OF INTERVIEWING A COMPLAINANT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

PRINTED NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

TITLE: \_\_\_\_\_

AGENCY AND/OR DIVISION: \_\_\_\_\_

WORK TELEPHONE NUMBER: \_\_\_\_\_

DATE COMPLAINT RECEIVED: \_\_\_\_\_

DATE FORM COMPLETED: \_\_\_\_\_

REASON FOR DELAY, IF ANY, BETWEEN THE DATE THE COMPLAINT WAS RECEIVED AND THE DATE THE FORM WAS COMPLETED:

NAME AND TITLE OF PERSON TO WHOM THE FORM WAS FORWARDED FOR ACTION:

DATE ON WHICH THE FORM WAS FORWARDED:

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