



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH

## Title VI of the Civil Rights Act of 1964

### Discrimination Complaint

Federal law prohibits discrimination against persons based on their race, color or national origin. You have the right to complain to the Tennessee Department of Health if you feel that you have been discriminated against for these reasons. Please give us the following information so that we can look into your complaint. If you need help in completing this form, please let us know.

1. What is the name of the person discriminated against?

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, and Zip Code \_\_\_\_\_

Telephone (*Home*) (\_\_\_\_) \_\_\_\_\_ (*Business*) (\_\_\_\_) \_\_\_\_\_

2. What is the name and address of the institution, agency, or person that you believe discriminated against you?

Name \_\_\_\_\_

Address: \_\_\_\_\_

City, State, and Zip Code \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_

3. What was the reason you believe you were discriminated against? Was it because of your:

a. Race

b. Color

c. National Origin

4. When do you believe that the discrimination took place? \_\_\_\_\_

5. In your own words, explain what happened and who you believe was responsible. Please be as specific as possible. You may attach additional sheets if needed.

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6. Have you tried to resolve this complaint with the institution, agency or person?  Yes  No  
If yes, what is the status of the complaint?

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7. Are you filing this complaint for someone else?  Yes  No

If yes, against whom do you believe the discrimination was directed?

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

8. Have you filed this complaint with any other federal, state, or local agency, or with any federal or state court?  Yes  No

If yes, check all that apply      Federal agency       Federal court       State agency   
   State court       Local agency

9. What is the name of the contact person at the agency/court where the complaint was filed?

Name \_\_\_\_\_

Agency/Court Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, and Zip Code \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_

10. Please sign below. You may attach any written materials or other information that you think can be helpful to us in looking into your complaint.

\_\_\_\_\_  
Complainant's Signature

\_\_\_\_\_  
Date

Mail this form to:

**Title VI Compliance Officer**  
**Tennessee Department of Health**  
**Office of Minority Health**  
**425 5<sup>th</sup> Avenue North**  
**Cordell Hull Building, 3<sup>rd</sup> Floor**  
**Nashville, TN 37243**  
**Phone: (615) 741-9421**  
**Email: [Luvenia.Butler@state.tn.us](mailto:Luvenia.Butler@state.tn.us)**

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Filing a complaint with our Title VI Office is voluntary. However, without the information requested above, our Title VI Office may be unable to proceed with your complaint. We collect this information under authority of Title VI of the Civil Rights Act of 1964, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from Tennessee Department of Health to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You may also email or write a letter and send it to the address above.

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