



**American-Arab
Anti-Discrimination
Committee**

National Office

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Incident Report / Discrimination Claim

*Please fill out this form clearly. Describe the incident with enough information so we can better understand your complaint. The information you provide will remain confidential during the investigation and verification of the incident.**

Name _____ Date _____

Address: _____

City _____ State _____ Zip _____

Phone _____ Email _____

Signature _____

**Membership in ADC is required in order to receive legal help.*

Incident Information

Category of Discrimination:	<input type="checkbox"/> Education	<input type="checkbox"/> Employment	<input type="checkbox"/> Entertainment
	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Media	<input type="checkbox"/> Religious
	<input type="checkbox"/> Other _____		
Cause/Reason of Discrimination:	<input type="checkbox"/> Age	<input type="checkbox"/> Color	<input type="checkbox"/> Gender
	<input type="checkbox"/> National Origin	<input type="checkbox"/> Race	<input type="checkbox"/> Religion
	<input type="checkbox"/> Other _____		

Incident Report to _____

Date of Incident _____ Time of Incident _____

Address/Location of Incident _____

Involved Party Name(s) _____

Please use the following space (attach additional sheets, if necessary) to describe the incident (s):
