LAMPREY
HEALTH CARE
Where Excellence and Caring go Hand in Hand

TITLE VI COMPLAINT FORM

Title VI of the Civil Rights Act of 1964 states "No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Please provide the following information necessary in order to process your complaint. Should you require any assistance in completing this form, please let us know. Please complete this form and mail or deliver to:

Compliance Officer, Lamprey Health Care, 207 South Main Street, Newmarket, NH 03857
You can reach our office Monday-Friday from 9:00 AM - 4:00 PM at 603-659-2494

1. **Name** _____

2. **Street Address** _____

3. **City, State and Zip Code** _____

4. **Telephone Number Home/Cell:** _____ **Work:** _____

5. **Are you filing this complaint on your own behalf?** ☐ Yes* ☐ No

**If Yes please continue to question 7*

If No, please supply the name of the person for whom you are complaining and your relationship to him/her:

Name: _____ Relationship: _____

6. **Have you obtained permission to file on behalf of the complainant?** ☐ Yes ☐ No

7. **What was the alleged discrimination based on?** (Check all that apply)

☐ Race ☐ Color ☐ National Origin

8. **Date of incident resulting in the alleged discrimination?** _____

Este documento está disponible en español bajo petición.

9. **Please explain as clearly as possible what happened and why you believe you were discriminated against. Include the name and contact information of the person(s) who discriminated against you (if known) as well as the names and contact information of any witnesses.**

   If additional space is needed, please attach sheets of paper or use the back of this form.

_____

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10. **Have you previously filed a Title VI complaint with this agency?** ☐ Yes ☐ No

11. **Have you filed this complaint with any other federal, state, or local agency; or with a federal or state court?**

    (Check the appropriate box) ☐ Yes ☐ No

    If yes, please check each agency the complaint was filed with:

    ☐ Federal agency ☐ Federal court ☐ State agency ☐ State court ☐Local agency

12. **Please provide the name of a contact person at the agency/court where the complaint was also filed:**

    Name_____

    Address_____

    City, State and Zip Code_____

    Telephone Number_____

Please sign below. You may attach any written materials or information you believe supports your complaint.

_____ _____

Signature Date

Please submit this form in person at the address below, or mail this form to:

Compliance Office
Lamprey Health Care
207 South Main Street
Newmarket, NH 03857

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