**EMPLOYEE COMPLAINT ASSISTANCE PROGRAM AGENCY NEEDS ASSESSMENT QUESTIONNAIRE**

(Please complete the following questions and email it oseeoc.dbm@maryand.gov. A response will be forwarded within 24 hrs.)

1. What is the name of the requesting agency?

Click or tap here to enter text.

1. Please explain the conflict/reason for requesting assistance.

Click or tap here to enter text.

1. Provide an overview of the complaint.

 (Please include the following: alleged discriminatory violation, issue(s), parties involved in complaint, date of alleged violation, and summary of complaint.)

 Click or tap here to enter text.

1. Person to contact should reviewer have any questions.

Click or tap here to enter text.

1. Telephone number and email address of contact person.

Click or tap here to enter text.

Do not write below this line. Reviewer will return form with this section completed.

Decision: [ ]  Granted [ ] Denied

Reviewer’s explanation: Click or tap here to enter text.

Reviewer’s Name and telephone number/email Click or tap here to enter text.

Date: Click or tap to enter a date.