Radiant Health Centers
Compassionate Care for All

Title VI Complaint Form

Section I: ***Please write legibly***		
1. Name:		
2. Address:		
3. Telephone:	3.a.Secondary Phone *(Optional):*	
4. Email Address:		
5. Accessible Format Requirements?	[ ] Large Print	[ ] Audio Tape
	[ ] TDD	[ ] Other

Section II:		
6. Are you filing this complaint on your own behalf?	YES*	NO
*If you answered "yes" to #6, go to Section III.		
7. If you answered "no" to #6, what is the name of the person for whom you are filing this complaint? Name:		
8. What is your relationship with this individual:		
9. Please explain why you have filed for a third party:		
10. Please confirm that you have obtained permission of the aggrieved party to file on their behalf.	YES	NO

Section III:
11. I believe the discrimination I experienced was based on *(check all that apply):* **[ ] Race [ ] Color [ ] National Origin**
12. Date of alleged discrimination: (*mm/dd/yyyy)*
13. Explain as clearly as possible what happened and why you believe you were discriminated against. Describe all persons who were involved. Include the name and contact information of the person(s) who discriminated against you (if known), as well as names and contact information of any witnesses. If more space is needed, please attach additional sheets of paper.

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COMPLAINT FORM Section IV:		
14. Have you previously filed a Title VI complaint with Radiant Health Centers?	YES	NO
Section V:		
15. 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 _____ [ ] State Agency _____ [ ] Federal Court _____ [ ] Local Agency _____ [ ] State Court _____		
16. If you answered "yes" to #15, provide information about a contact person at the agency/court where the complaint was filed.		
Name:		
Title:		
Agency:		
Address:		
Telephone: Email:		
Section VI:		
Name of Transit Agency complaint is against:		
Contact Person:		
Telephone:		

You may attach any written materials or other information that you think is relevant to your complaint.

Signature_____ Date_____
(Signature and date are required below to complete form)

Please submit this form in person or mail this form to:
Director of Support Services
Radiant Health Centers
17982 Sky Park Circle, Suite J
Irvine, CA 92614