DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)

See OMB Statement on Reverse.

CIVIL RIGHTS DISCRIMINATION COMPLAINT

YOUR FIRST NAME	YOUR LAST NAME
Matthew	Bowman
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)
	(202) 393-8690

STREET ADDRESS	CITY
Attorney for [redacted], Alliance Defense Fund, 801 G Street NW	Washington

STATE	ZIP	E-MAIL ADDRESS (If available)
DC	20001	mbowman@telladf.org

Are you filing this complaint for someone else? ☒ Yes ☐ No

If Yes, whose civil rights do you believe were violated?

FIRST NAME	LAST NAME
[redacted]	[redacted]

I believe that I have been (or someone else has been) discriminated against on the basis of:

☐ Race / Color / National Origin ☐ Age ☐ Religion ☐ Sex
☐ Disability ☐ Other (specify): the right not to be discriminated against for objecting to assist abortions, 42 U.S.C. § 300a-7(c) & (e)

Who or what agency or organization do you believe discriminated against you (or someone else)?
PERSON/AGENCY/ORGANIZATION

Vanderbilt University, Vanderbilt University Medical Center Nurse Residency Program, Vanderbilt University Medical Center Recruitment

STREET ADDRESS	CITY
Village at Vanderbilt, Att: Vanderbilt Nurse Residency Program Committee, 1500 21st Ave. S. Suite 1516	Nashville

STATE	ZIP	PHONE (Please include area code)
TN	37,212	+1 (615) 322-5000

When do you believe that the civil right discrimination occurred?
LIST DATE(S)

November 29, 2010 and Ongoing

Describe briefly what happened. How and why do you believe that you have been (or someone else has been) discriminated against? Please be as specific as possible. (Attach additional pages as needed)

See attached letter with explanation.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE [redacted] DATE *(mm/dd/yyyy)* 1/7/11

Filing a complaint with OCR is voluntary. Ho[redacted]d above, OCR may be unable to proceed with your complaint. We collect this information under authority of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of1973 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 of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS 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 also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: **www.hhs.gov/ocr/civilrights/complaints/index.html**. To mail a complaint see reverse page for OCR Regional addresses.

PSC Graphics (301) 443-1090 EF

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Cassette tape ☐ Computer diskette ☐ Electronic mail ☐ TDD

☐ Sign language interpreter (specify language): _____

☐ Foreign language interpreter (specify language): _____ ☐ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME	LAST NAME
Matthew	Bowman
HOME PHONE (Please include area code)	WORK PHONE (Please include area code)
	+1 (202) 393-8690

STREET ADDRESS	CITY
Attorney for [redacted], Alliance Defense Fund, 801 G Street NW	Washington

STATE	ZIP	E MAIL ADDRESS (If available)
DC	20,001	mbowman@telladf.org

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

No

DATE(S) FILED	CASE NUMBER(S) (If known)

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one)

☐ Hispanic or Latino

☐ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then English) _____

How did you learn about the Office for Civil Rights?

☐ HHS Website/Internet Search ☐ Family/Friend/Associate ☐ Religious/Community Org ☒ Lawyer/Legal Org ☐ Phone Directory ☐ Employer

☐ Fed/State/Local Gov ☐ Healthcare Provider/Health Plan ☐ Conference/OCR Brochure ☐ Other (specify): _____

To mail a complaint, please type or print, and return completed complaint to the OCR Regional Address based on the region where the alleged violation took place. If you need assistance completing this form, contact the appropriate region listed below.

Region I - CT, ME, MA, NH, RI, VT
Office for Civil Rights, DHHS
JFK Federal Building Room 1875
Boston, MA 02203
(617) 565 1340; (617) 565 1343 (TDD)
(617) 565 3809 FAX

Region II - NJ, NY, PR, VI
Office for Civil Rights, DHHS
26 Federal Plaza Suite 3313
New York, NY 10278
(212) 264 3313; (212) 264 2355 (TDD)
(212) 264 3039 FAX

Region III - DE, DC, MD, PA, VA, WV
Office for Civil Rights, DHHS
150 S. Independence Mall West Suite 372
Philadelphia, PA 19106 3499
(215) 861 4441; (215) 861 4440 (TDD)
(215) 861 4431 FAX

Region IV - AL, FL, GA, KY, MS, NC, SC, TN
Office for Civil Rights, DHHS
61 Forsyth Street, SW. Suite 3B70
Atlanta, GA 30303 8909
(404) 562 7886; (404) 331 2867 (TDD)
(404) 562 7881 FAX

Region V - IL, IN, MI, MN, OH, WI
Office for Civil Rights, DHHS
233 N. Michigan Ave. Suite 240
Chicago, IL 60601
(312) 886 2359; (312) 353 5693 (TDD)
(312) 886 1807 FAX

Region VI - AR, LA, NM, OK, TX
Office for Civil Rights, DHHS
1301 Young Street Suite 1169
Dallas, TX 75202
(214) 767 4056; (214) 767 8940 (TDD)
(214) 767 0432 FAX

Region VII - IA, KS, MO, NE
Office for Civil Rights, DHHS
601 East 12th Street Room 248
Kansas City, MO 64106
(816) 426 7277; (816) 426 7065 (TDD)
(816) 426 3686 FAX

Region VIII - CO, MT, ND, SD, UT, WY
Office for Civil Rights, DHHS
1961 Stout Street Room 1426
Denver, CO 80294
(303) 844 2024; (303) 844 3439 (TDD)
(303) 844 2025 FAX

Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions
Office for Civil Rights, DHHS
90 7th Street, Suite 4 100
San Francisco, CA 94103
(415) 437 8310; (415) 437 8311 (TDD)
(415) 437 8329 FAX

Region X - AK, ID, OR, WA
Office for Civil Rights, DHHS
2201 Sixth Avenue Mail Stop RX 11
Seattle, WA 98121
(206) 615 2290; (206) 615 2296 (TDD)
(206) 615 2297 FAX

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**