

EQUAL EMPLOYMENT OPPORTUNITY DISCRIMINATION COMPLAINT APPEAL FORM

COMMONWEALTH OF PENNSYLVANIA
STD-486A REV. 02/14

CASE/DOCKET NUMBER	DATE OF COMPLAINT
COMPLAINANT'S NAME	EMPLOYEE NUMBER
COMPLAINANT ADDRESS	AGENCY NAME AND ADDRESS
COMPLAINANT CONTACT NUMBERS	AGENCY CONTACT NUMBERS
CURRENT COMMONWEALTH EMPLOYEE <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF NOTIFICATION LETTER*
PLEASE INDICATE WHY AN APPEAL IS REQUESTED IN THIS CASE (USE ADDITIONAL PAPER IF NEEDED)	

*THIS APPEAL MUST BE SUBMITTED WITHIN 20 CALENDAR DAYS OF RECEIPT OF LETTER ADVISING OF THE RECONSIDERATION DETERMINATION.

**OFFICE OF ADMINISTRATION
OFFICE FOR HUMAN RESOURCES MANAGEMENT
EQUAL EMPLOYMENT OPPORTUNITY DIVISION
FINANCE BUILDING, ROOM 222
613 NORTH STREET
HARRISBURG, PA 17120
PHONE: 717.783.1130 FAX 717.772.3302**

COMPLAINANT'S SIGNATURE	DATE
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