

OKLAHOMA DEPARTMENT OF CORRECTIONS
CONFLICT RESOLUTION REQUEST FORM

INSTRUCTIONS FOR COMPLETION		FOR AGENCY USE ONLY													
You must complete this form and file it with your agency conflict resolution manager. If you are filing a dispute alleging discrimination, you must complete the information on the right side of this form.		FILED (Stamp)													
		CONFLICT RESOLUTION NUMBER:													
• Please print or type • Submit the original and attach any relevant documents • Do not submit documents which you want returned. • For further information on the internal agency conflict resolution procedure see OP-110205 entitled "Employee Conflict Resolution Procedures."		FOR USE WHEN FILING ALLEGATIONS OF DISCRIMINATION ONLY I certify by my signature on this form that this dispute describes an adverse employment condition which I believe occurred or was directed at me due to: (check all that apply) <table><tbody><tr><td>☐ Political opinion or affiliation</td><td>☐ National Origin</td></tr><tr><td>☐ Religious opinion or affiliation</td><td>☐ Disability</td></tr><tr><td>☐ Race</td><td>☐ Sexual Harassment</td></tr><tr><td>☐ Creed</td><td>☐ Retaliation/Reprisal</td></tr><tr><td>☐ Gender</td><td>☐ Color</td></tr><tr><td>☐ Age over 40</td><td></td></tr></tbody></table>		☐ Political opinion or affiliation	☐ National Origin	☐ Religious opinion or affiliation	☐ Disability	☐ Race	☐ Sexual Harassment	☐ Creed	☐ Retaliation/Reprisal	☐ Gender	☐ Color	☐ Age over 40	
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NAME (Last, First, Middle Initial)															
RACE/GENDER (for statistical purposes only)		FACILITY													
HOME ADDRESS (Street Number, P.O. Box, State, Zip Code)															
WORK TELEPHONE ()		HOME TELEPHONE ()													
JOB FAMILY CODE		PAY BAND													
JOB FAMILY TITLE															
REPRESENTATIVE (Name, Address, and Telephone Number)															
SPOKESPERSON--FOR GROUP COMPLAINTS ONLY (Name, Address, and Telephone Number)															
I believe the following provisions of the State Statute, Admin Rules, or other agency policy, procedure, or rules have been violated: _____ _____															
BRIEFLY DESCRIBE ACTIONS TAKEN WITH YOUR SUPERVISOR TO RESOLVE THIS ISSUE--INCLUDE THE NAME OF THE SUPERVISOR AND THE DATE OF THE DISCUSSION. This section OR proof of mediation is mandatory to complete per OP-110205. Name of Supervisor _____ Date _____															
DID YOU ATTEMPT TO RESOLVE THIS DISPUTE THROUGH MEDIATION? [] YES [] NO															
IF YES, PROVIDE DATE OF MEDIATION SESSION: _____															
It may be necessary to reach you at work in the course of the investigation. Please check here if you do not want messages left with members of your chain of command concerning this complaint. ☐															

REASON FOR CONFLICT (Be specific as to the reason you are filing this complaint and include specific facts, names, dates, places, etc. to include facility/party against whom complaint is being filed. Attach additional sheets if necessary):

REMEDY (Briefly state the remedy or relief you are seeking from this issue):

Misrepresentation or falsification of this document is a violation of the Oklahoma State Statute. I declare that I have read this complaint and the statements contained herein are true to the best of my knowledge and belief.

Signature of Employee _____ Date _____