COMPLAINT

Discrimination Based on Health Care Choices

Use this complaint form to report a violation of Section 381.00316 Florida Statutes (2023)

Your Last Name: ______________________________ Your First Name: ______________________________

Home Address: ____

City: ______________________________ State: ____________________ Zip Code: ________________

Home Telephone: ______________________________ Cellular Telephone: ______________________________

Email Address: ____

Confirm Email Address: ____

Date of Adverse Action Taken (On Or After June 1, 2023): ______________________________

1. This complaint pertains to:

   A COVID-19 Restriction or Requirement

   Other Vaccine Requirement

2. This complaint is filed against (select one Subject type):

   A Business, Charitable Organization, or Corporation Not-For-Profit

   A Governmental Entity

   A hospital or ambulatory surgical center licensed in accordance with Chapter 395, Florida Statutes

Subject's Name: ____

Subject's Address: ____

Subject's Telephone Number: ____

Location Where Adverse Action Occurred: ____

3. To gain access, enter, or receive services, the Subject required that I provide:

   Proof of receipt of COVID-19 vaccine, emergency use authorization vaccine, or mRNA vaccine

   Proof of post-infection recovery from COVID-19

   Copy of my COVID-19 test result

   N/A

4. As a condition of obtaining a contract, job, promotion, or continued employment, the Subject required that I provide:

   Proof of receipt of COVID-19 vaccine, emergency use authorization vaccine, or mRNA vaccine

   Proof of post-infection recovery from COVID-19

   Copy of my COVID-19 test result

   N/A

5. I was discharged, refused employment, deprived of employment opportunities, otherwise adversely affected, or discriminated against based on my choice not to:

   Obtain a COVID-19 vaccine, emergency use authorization vaccine, or mRNA vaccine

   Document post-infection recovery from COVID-19

   Submit a COVID-19 test result

   N/A

6. I submitted a [ ] religious or [ ] medical exemption request in accordance with federal law to opt out of a vaccine requirement other than COVID-19, emergency use authorization, or mRNA, and the Subject denied me an exemption or reasonable accommodation. This discrimination occurred when I was:

   Denied access, entry, or services

   Denied contracting, hiring, promotion, or continued employment

   Discharged, refused employment, deprived of employment opportunities, or otherwise adversely affected

   N/A

For Number 6., please provide a copy of your exemption request and the Subject's denial when submitting your complaint.

7. I was required to wear a face mask, shield, or covering over the mouth and nose outside of a health care, occupational, or laboratory safety requirement, and the Subject:

   Denied me access, entrance, services, or admission

   Discharged, refused employment, deprived me of employment opportunities, or otherwise adversely affected me

   N/A

(Continued on next page)

8. Please provide or attach a detailed explanation of the adverse action the Subject took against you and provide documentation that supports this complaint.

I declare that the statements made in connection with this complaint are true and correct to the best of my knowledge and belief. I understand the information contained herein is subject to verification and agree to provide such documentation or verification as required. I understand that if I fail to provide any such documentation or respond to requests for verification, this complaint may be dismissed.

I also understand that the Office of the Attorney General of Florida does not give legal advice, and that the Office of the Attorney General of Florida cannot take legal action for me individually. Further, I understand that the information submitted with this complaint may be provided to the Subject named in the complaint and may also be subject to public inspection pursuant to Chapter 119, Florida Statutes.

Complainant Signature: ______________________________ Dated: ____________________

Please email the completed form to HealthCareChoices@myfloridalegal.com