

CERTIFICATE OF NON-DISCRIMINATION*

The governing board of _____ maintains the following policy of non-discrimination: (Name of Organization)

1. No person is excluded from agency programs or benefits because of race, color, religion, gender, national origin, ancestry, age, medical condition, disability, veteran status, marital status, sexual orientation or any other characteristic protected by law.
2. There is no discrimination on the basis of race, color, religion, gender, national origin, ancestry, age, medical condition, disability, veteran status, marital status, sexual orientation or any other characteristic protected by law with regard to hiring, assignment, promotion or other conditions of staff employment.
3. There is no discrimination on the basis of race, color, religion, gender, national origin, ancestry, age, medical condition, disability, veteran status, marital status, sexual orientation or any other characteristic protected by law on the agency's governing body.

I certify that the practices of this organization conform to the policy of non-discrimination stated above.

Typed or printed name of President or Board Chairperson

Date:

Signature of President or Authorized Official

Name of Organization

*The Connecticut Breast Health Initiative, Inc. will not knowingly support organizations, projects and programs that discriminate in their employment practices or delivery of programs or services on the basis of race, color, religion, gender, national origin, ancestry, age, medical condition, disability, veteran status, marital status, sexual orientation or any other characteristic protected by law. We therefore require that all grant applicants submit a signed Certificate of Non-Discrimination confirming compliance with all applicable local, state and federal anti-discrimination laws.