

**Florida Atlantic University Foundation, Inc.  
Whistleblower Form**

The Florida Atlantic University Foundation, Inc. Code of Conduct (hereinafter referred to as the Code) requires directors, other volunteers, and employees to observe high standards of business and personal ethics in the conduct of their duties and responsibilities. Employees and representatives of the organization must practice honesty and integrity in fulfilling their responsibilities and comply with all applicable laws and regulations.

The whistleblower protection policy is being implemented at Florida Atlantic University Foundation, Inc. to comply with the Public Company Accounting Reform and Investor Protection Act of 2002 (Sarbanes-Oxley). Any staff member or volunteer who reports waste, fraud, or abuse will not be fired or otherwise retaliated against for making the report.

DATE: \_\_\_\_\_

<b>YOUR INFORMATION (Optional)*</b>		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIPCODE:
DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDRESS:
<b>WHISTLEBLOWERS MAY FILE ANONYMOUSLY</b>	DEPARTMENT:	SUPERVISORS NAME:
<b>CONSENT TO DISCLOSE YOUR NAME</b>		
PLEASE SELECT ONE OF THE FOLLOWING:		
<input type="checkbox"/> I CONSENT TO MY NAME BEING DISCLOSED TO INVESTIGATE THIS COMPLAINT.		
<input type="checkbox"/> I DO NOT CONSENT TO MY NAME BEING DISCLOSED.		
NAME OF DEPARTMENT YOUR COMPLAINT IS AGAINST:	NAME OF PERSON YOUR COMPLAINT IS AGAINST:	DATE(S) ACTION(S) OCCURRED:
PLEASE PROVIDE A DETAILED DESCRIPTION OF WHAT HAPPENED:		
DO YOU HAVE ANY WITNESSES? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES, PLEASE PROVIDE THE NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF YOUR WITNESSES BELOW:		
WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER: ( )
WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER: ( )
WITNESS NAME:	ADDRESS:	TELEPHONE NUMBER: ( )

\* Provide contact information if you would like to receive a summary of findings from investigation.