TITLE II OF THE AMERICANS WITH DISABILITIES ACT (ADA)

DISCRIMINATION COMPLAINT/GRIEVANCE FORM

Please complete this form in black ink or type. Alternate means of filing a Complaint/Grievance, such as a personal interview or audio recording, will be made available upon request to the City or Town of_____, ADA Coordinator.

Complainant Name: _____

Complainant Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Complete the information below IF the Person discriminated against is not the Complainant:

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Date and Time of Alleged Discrimination: _____

Location of Alleged Discrimination: _____

Please describe the act(s) of discrimination providing the Name(s) where possible of individuals whom allegedly discriminated (if applicable,) or City Facilities in violation of the Americans with Disabilities Act (ADA.) Attach additional pages if necessary:

_____

What type of Corrective Action is the Complainant Seeking:

_____

_____

_____

_____

_____

_____

Has the Complaint been filed with another Federal, State, or Local Civil Rights Agency or Court?

Yes: _____ No: _____

If yes, with what Agency or Court: _____

Contact Person: _____

Address: _____

City, State, Zip Code: _____

Contact Telephone Number: _____

Date Filed: _____

Does Complainant Intend to File with another Agency or Court: Yes: _____ No: _____

Agency or Court: _____

Address: _____

City, State, Zip Code: _____

Contact Telephone Number: _____

Additional Space for Answers: _____

_____

_____

Signature of Complainant: _____

Printed/Typed Name of Complainant: _____

Date Form Completed: _____

PLEASE RETURN COMPLETED FORM TO:

ADA Coordinator, _____

For ADA Coordinator Use Only:

Date Completed Form Received _____