ADA COMPLAINT FORM

Name: ____

Address:____

City:______________________ State: Zip Code:____________

Home Phone Number:______________ Cell Number:_______________

Person discriminated against:_________________________________

Address of person discriminated against (if other than you):______________

City:_______________________State:_______Zip Code:____________

What was the date of the alleged discrimination?_____________________

Where did the alleged discrimination take place?_____________________

Describe the alleged discriminatory action: (Please add extra sheets if necessary)

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Please list any and all witnesses' names and phone numbers:______________

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What steps have you taken to address the conflict or problem?____________

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What type of corrective action took place?__________________________

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What remedy are you seeking?_________________________________

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Please attach any documents you have which support the allegation. Then date and sign this form and send it to the ADA Coordinator:___________________

________________________ ________________________

Complainant Signature Date

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Print your name