AMERICANS WITH DISABILITY ACT

COMPLAINT FORM AND REASONABLE MODIFICATION REQUEST FORM

Full Name (Complainant):		
Phone Number: ( )	Email:	
Address:		
City:	State:	Zip Code:

Preferred Contact Method:

- [ ] Phone
- [ ] E-mail
- [ ] US Mail
- [ ] Other: ____

Are you filing this complaint on your own behalf?

- [ ] Yes
- [ ] No

If not, please provide the name and relationship to the person for who you are filing the complaint:

Name:

Relationship:

Date of alleged disability discrimination:	Time of Day:

Name/Position (Title) of person(s) who allegedly discriminated against you:

Location of incident:	Date of incident:

Explain as clearly as possible what happened and why you believe you were discriminated against or the detail of your reasonable modification request:

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(Attach a separate sheet, if necessary)
How can this/these issue(s) be resolved to your satisfaction?
List Witness(es): (Attach a separate sheet, if necessary) Name: Phone Number: ( ) Name: Phone Number: ( ) Name: Phone Number: ( )
Have you filed the complaint with anyone else? ☐ Yes ☐ No If Yes, who:

By signing below, you agree that you have read, understand and accept the terms and procedures for tracking and investigating ADA complaints and you affirm that the information above is true to the best of your knowledge.

____

Signature

____

Printed Name

____

Date

Send this completed form along with any written materials or other information that you think is relevant to your complaint or request.