AMERICANS WITH DISABILITIES ACT COMPLAINT FORM

1. Complainant's Information:

Date complaint filed with the County:_____

First Name:_____ Last Name:_____

Address:_____ City:_____

State: _____ Zip Code:_____

Home Phone #:_____ Mobile Phone #:_____

Email Address:_____

2. Information on Violation:

Date violation occurred:_____ Do you have a disability?_____

Describe the disability:_____

_____

Location violation occurred:_____

Which County Department?_____

Describe violation:_____

_____

_____

_____

3. Resolution

What resolution or accommodation are you seeking?_____

_____

_____

_____

_____