## AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM

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| Name: | Home Phone Number: |
| Address: | Work Phone Number: |

Complaint is against what County office, agency, or employee?

Address:

Date alledged violation occurred:

Describe the particular way in which you believe you have been denied access to any service, program, and/or acitvity, or have otherwise been discriminated against because of, or related to, a disability. Please specify dates, times of incidents, locations, and names or positions of County employees involved. Provide names, addresses and telephone numbers of any witnesses. Please attach additional pages if necessary.

Additional information: is_☐_ is not_☐_ attached.

Describe the corrective action or remedy you are seeking:

Have you filed this complaint with any Federal, State or local agency? Yes ☐ No ☐

If yes, with whom? Date filed:

I declare under penalty of perjury that the facts and circumstances given above are true and correct to the best of my knowledge and belief. I further authorize the ADA Coordinator or his/her designated representative access to all appropriate medical, judicial, legal, and/or administrative record or files relevant to an investigation of this complaint.

Date: Signature:

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| Human Resources Use Only<br>Date Received | PLEASE SUBMIT COMPLETED FORM TO THE ADA COORDINATOR<br>LOCATED AT:<br>940 WEST MAIN STREET, SUITE 101, EL CENTRO, CA 92243<br>(760) 482-4488/TTY: (760) 482-4196<br><br>Human Resources & Risk Management<br>COUNTY OF IMPERIAL |