CITY OF EMERYVILLE

INCORPORATED 1896

AMERICANS WITH DISABILITIES ACT (ADA) COORDINATOR
1333 PARK AVENUE
EMERYVILLE, CALIFORNIA 94608–3517

TEL: (510) 450-7801 FAX: (510) 450-7831

SMLAY@EMERYVILLE.ORG

Title II of the Americans with Disabilities Act & Section 504 of the Rehabilitation Act of 1973

GRIEVANCE FORM

I. COMPLAINANT INFORMATION

Name of Complainant: _____
Last MI First

Address: _____

City: _____State: _____Zip Code: _____

Telephone Number: _____ E-mail address: _____

Preferred Method(s) of Communication: (Check all that apply) ☐ Voice Telephone,

☐ TTY ☐ CRS☐ E-mail☐ US MAIL ☐ Other: _____

II. DESCRIBE YOUR COMPLAINT OF DISCRIMINATION BASED UPON DISABILITY. Be specific and give date(s), time(s) and location(s). Use the reverse side of this sheet or attached pages, if needed.

III. PERSONS NAMED IN YOUR COMPLAINT. List the names of (or describe) all persons involved in your complaint. Indicate the job title and City Agency, department or division of City employees, if possible.

IV. WITNESSES TO YOUR COMPLAINT. List the names of (or describe) all persons involved in your complaint. Indicate the job title and City Agency, department or division of City employees, if possible.

V. EVIDENCE AND DOCUMENTATION. List and provide any physical evidence, written or recorded documents, or any other information that directly supports your specific claim of discrimination.

VI. CASE REMEDY AND/OR RESOLUTION. What remedies or resolutions are you seeking?

CERTIFICATION

I herby certify that the information and statements provided above are true.

Signature: _____ Date: _____

If Complainant is not the individual completing this form, please provide

Representative's Name: _____

Address:_____Telephone Number:_____

For more information or assistance in completing the form, please contact the ADA Coordinator via (direct line) 510.450.7801, (fax) 510.450.7831, (TTY Relay) 711, or smlay@emeryville.org