

## Olmsted County Public Rights of Way - Title II of the Americans with Disabilities Act and - Section 504 of the Rehabilitation Act of 1973 Discrimination Complaint Form

Instructions: Please fill this form completely, in black ink or type. Sign and return to the ADA Coordinator as specified in **Appendix D**. Attach additional sheets if necessary.

Complainant Name:

Street Address:

City, State, and Zip Code:

Telephone (Home):

Telephone (Business):

Person Discriminated Against (if other than the complainant):

Address:

City, State, and Zip Code:

Telephone (Home/Business or Both):

**Government, organization, or institution which you believe has discriminated:**

Name:

Street Address:

City:

County:

State and Zip Code:

Telephone Number:

When was the issue discovered/when did the problem occur? (Date):

Describe the issue in detail, providing the name(s) of the individuals contacted, where possible. (Add additional pages if necessary):

Have prior efforts been made to resolve this complaint through the grievance procedure?

Yes ☐ No ☐

If Yes, what is the status of the grievance?

Has the complaint been filed with another bureau of the Department of Justice or any other Federal, State, or local civil rights agency or court?

Yes ☐ No ☐

If Yes: Agency or Court:

Contact Person:

Street Address:

City, State, and Zip Code:

Telephone Number:

Date Filed:

Do you intend to file with another agency or court? Yes ☐ No ☐

If Yes: Agency or Court:

Address:

Telephone Number:

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Return to:

ADA Coordinator as specified in **Appendix D** of the Transition Plan.