Americans with Disabilities Act of 1990
Statement of Grievance

Name of individual making the complaint: _____

Address: _____

City: _____, State: _____ Zip: _____

Daytime Telephone: _____

Evening Telephone: _____

Complete the following section if the complaint is being filed by a person other than the individual making the complaint:

Complaint filed by: _____

Title (If appropriate): _____

Firm (If appropriate): _____

Address: _____

City: _____, State: _____ Zip: _____

Daytime Telephone: _____

Evening Telephone: _____

This Section is for Court use only:

Date Filed: _____ Time: _____

Complaint take by; _____

Staff person's name

Complaint's Full Name: _____

Name the court or court facility in which the violation is alleged to have occurred:

_____

Describe what happened that led to the decision to file this complaint. (If necessary, use additional page(s) to complete the statement.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Complaint's Full Name: _____

State the desired remedy or the solution requested:

_____

_____

_____

_____

_____

_____

_____

_____

_____

List those witnesses who can provide information that supports or is relevant to your complaint:

Witness: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone: _____

Evening Telephone: _____

Witness: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone: _____

Evening Telephone: _____

Complaint's Full Name: _____

Continued from question Number _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If necessary, use additional page(s) to complete the statement