
**AMERICANS WITH DISABILITIES ACT OF 1990
STATEMENT OF GRIEVANCE**

Name of Individual Making the Complaint _____

Address _____

City _____ State _____ Zip _____

Day Telephone _____ Evening Telephone _____

Complete this 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 _____

Day Telephone _____ Evening Telephone _____

Complete this section to provide information as to your complaint.

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

3. State the desired remedy or the solution requested.

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

Witness _____

Address _____

City _____ State _____ Zip _____

Day Telephone (____) _____ Evening Telephone (____) _____

Witness _____

Address _____

City _____ State _____ Zip _____

Day Telephone (____) _____ Evening Telephone (____) _____

Witness _____

Address _____

City _____ State _____ Zip _____

Day Telephone (____) _____ Evening Telephone (____) _____

This section is for court use only.

Date filed _____

Time Filed _____

Complaint Taken By _____

Staff Person's Name