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.

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

3. State the desired remedy or the solution requested.

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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