**Title II of the American with Disabilities Act**

**Complaint Form**

Name

First Middle Initial Last

Home Address

Number Street Apt #

City Zip Code

Preferred Method of Contact:

Home Phone Mail (Large Print)

Cell Phone Email Address

Are you filing this Complaint on behalf of yourself?

Yes ❑ No ❑

If No, please complete information below

Name of Person completing

Relationship Phone Number

Date of Alleged Incident:

Time of Alleged Incident:

Location of Alleged Incident:

Please describe in detail what happened and explain why you believe you experienced discrimination. Be specific about the events, including any actions or behaviors that led you to feel discriminated against. If possible, provide the names and contact information of the person(s) you believe were responsible for the discrimination. Additionally, please include the names and contact details of any witnesses who were present during the incident.

Your Signature (Enter Full Name)

Your Representative Signature

Date