

Title II of the Americans with Disabilities Act COMPLAINT FORM

Instructions: Please fill out this form completely, in black ink or type. Sign and return to the address on page 3.

Complainant:

Address:

City, State and Zip Code:

Telephone: Home:

Business:

Person Making the Complaint:
(if other than the complainant)

Address:

City, State, and Zip Code:

Telephone: Home:

Business:

Department/Agency which you believe has discriminated:

Name:

Address:

County:

City:

State and Zip Code:

Telephone Number:

When did the event occur? Date:

Describe the event providing the name(s) where possible for the individuals who were involved (use space on page 3 if necessary):

Has the complaint been filed with the Michigan Department of Civil Rights or the Federal Department of Justice or any other Federal agency or court?

Yes No

If yes:

Agency or Court:

Contact Person:

Address:

City, State, and Zip Code:

Telephone Number:

Date Filed:

Do you intend to file with another agency or court?

Yes No

Agency or Court:

Address:

City, State and Zip Code:

Telephone Number:

Additional space for answers:

Signature: _____

Date: _____

Return to:

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