STATE OF CALIFORNIA
DEPARTMENT OF GENERAL SERVICES
AMERICANS WITH DISABILITIES ACT (ADA)
GRIEVANCE FORM

INSTRUCTIONS

This is a printable form. Simply complete, print, and send to: Department of General Services, Att'n: ADA Coordinator, P.O. Box 989052, West Sacramento, CA 95798-9052

COMPLAINANT INFORMATION

NAME

ADDRESS

CITY **STATE** **ZIP CODE**

HOME PHONE (include area code) **BUSINESS PHONE (include area code)**

PERSON ALLEGING ADA VIOLATION *(if other than complainant)*

NAME

ADDRESS

CITY **STATE** **ZIP CODE**

HOME PHONE (include area code) **BUSINESS PHONE (include area code)**

INFORMATION ON ALLEGED VIOLATION

DATE ALLEGED VIOLATION OCCURRED

DESCRIPTION OF ALLEGED VIOLATION

REQUESTED REMEDY

HAS THIS COMPLAINT BEEN FILED WITH THE RESPONSIBLE FEDERAL ENFORCEMENT AGENCY, U.S. DEPARTMENT OF JUSTICE, OR COURT?

YES ☐ NO ☐

COMPLETE THE FOLLOWING IF YOU ANSWERED "YES" TO THE PREVIOUS QUESTION

AGENCY OR COURT

CONTACT PERSON

ADDRESS

CITY

STATE

ZIP CODE

PHONE (include area code)

DATE FILED

OTHER COMMENTS

SIGNATURE

DATE

PRINT