

**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