Accessibility Grievance Form

1. CONTACT INFORMATION:

NAME or
ORGANIZATION:_____

Title (if ORGANIZATION)
_____

CITY/ STATE/ ZIP:
_____

ADDRESS:
_____

TELEPHONE:
_____

2. CITY DEPARTMENT COMPLAINT IS AGAINST:

NAME of CITY DEPARTMENT: _____

NAME/TITLE (If known, department contact):_____

ADDRESS:_____
____

3. DOCUMENTATION:

Is this grievance based on previous proceedings, complaints, board meetings?

Yes _____

No _____

If yes, attach copies of any documents.

4. DESCRIPTION OF ALLEGED DISCRIMINATION:

Please include dates, persons involved, and recommended solution:

(If necessary, you may continue writing on the back of this form.)

_____

_____

_____

_____

5. ACKNOWLEDGMENT:

I certify all information is true and correct. I also certify that I have read this application and Grievance Committee procedures and fully understand all provisions therein. I agree that if any information given is false or misleading, the Accessibility *and* ADA Coordinator will have the right to reconsider the eligibility of this grievance. I understand this complaint form must be fully completed for its consideration.

Signature:_____ Date:_____

RETURN FORM TO:

City of El Paso

Office of Accessibility & ADA

Two Civic Center Plaza

El Paso, Texas 79901-1196

541-4243 Voice or TDD

FOR OFFICE USE ONLY:

Grievance Number: _____

Date Received: _____

Initials of Person Receive Complaint:_____

Action Taken:_____

Not Eligible __Voluntarily Resolved __Grievance Committee Hearing ___

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