



**CITY OF IMPERIAL
AMERICANS WITH DISABILITIES ACT (ADA) GRIEVANCE FORM
INSTRUCTIONS**

THIS IS A PRINTABLE FORM. SIMPLY COMPLETE, PRINT, AND SEND TO:
CITY OF IMPERIAL
ATTENTION: ADA COORDINATOR, 420 SOUTH IMPERIAL AVENUE, IMPERIAL, CA 92251

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
