AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM

1. Name and Address of Charging Party (Grievant)

   _____

   _____

   _____

2. Date: _____

3. Phone numbers where you may be reached:

   Home: _____

   Office: _____

4. Statement of grievance (please provide as detailed a statement as is possible and feel free to attach supplemental pages if necessary for a complete understanding of your concerns):

   _____

   _____

   _____

   _____

   _____

   _____

   _____

5. Please identify any documents or other materials that support your grievance. If documents or materials are in your possession, please attach copies to this grievance form.

   _____

   _____

   _____

   _____

AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM (Cont.)

6. Please identify what action or relief you are seeking as a result of this grievance.

_____

_____

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_____

_____

_____

_____
Signature of Grievant

IF, AS A RESULT OF A DISABILITY, YOU NEED ASSISTANCE IN COMPLETING THIS FORM, PLEASE CONTACT _____, THE DISTRICT'S ADA COMPLIANCE OFFICER, FOR ASSISTANCE OR ACCOMMODATION.

[Name of Compliance Officer]
[address]
[telephone number]