



AMERICANS WITH DISABILITIES COMPLAINT FORM

Instructions: Please fill out this form completely. Sign and return to the address on page 2.

Complainant			
Name:			
Address:			
City:		State:	Zip Code:
Business Phone:		Home Phone:	Mobile Phone:

Person Discriminated Against (if other than complainant)			
Name:			
Address:			
City:		State:	Zip Code:
Business Phone:		Home Phone:	Mobile Phone:

Person, Department, Office or Committee that you believe has discriminated			
Name:			
Address:			
City:		State:	Zip Code:
Phone:		Date of Discrimination:	

Describe the acts of discrimination providing the name(s) where possible of the individual(s) who discriminated (use space on back if necessary):

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What efforts have been made to resolve this complaint?

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What is the status of those efforts?

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Has a complaint been filed with a Federal, State, or local civil rights agency or court? Yes ___ No ___ If yes:

Federal, State or Local Civic Rights Agency or Court			
Name:			
Address:			
City:		State:	Zip Code:
Telephone:	Date Filed:		

Do you intend to file with another agency or court? Yes ___ No ___ If yes:

Other Agency or Court			
Name:			
Address:			
City:		State:	Zip Code:
Telephone:			

Signature: _____ Date: _____

Return to:

ADA Coordinator
Village of Glendale Heights
300 Civic Center
Glendale Heights, IL 60139