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# Americans with Disabilities Act of 1990

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## STATEMENT OF GRIEVANCE

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Name of Individual Making the Complaint: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day Telephone: \_\_\_\_\_ Evening Telephone: \_\_\_\_\_

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Complete the following section if the complaint is being filed  
by a person other than the individual making the complaint

Complaint Filed By: \_\_\_\_\_

Title (If appropriate) \_\_\_\_\_

Firm (If appropriate) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day Telephone: \_\_\_\_\_ Evening Telephone: \_\_\_\_\_

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This section is for court use only

Date Filed: \_\_\_\_\_ Time Filed: \_\_\_\_\_

Complaint Taken By: \_\_\_\_\_  
Staff Person's Name



Complainant's Law Name: \_\_\_\_\_

3. State the desired remedy or the solution requested:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. List those witnesses who can provide information that supports or is relevant to your complaint.

Witness: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day Telephone: \_\_\_\_\_ Evening Telephone: \_\_\_\_\_

Witness: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day Telephone: \_\_\_\_\_ Evening Telephone: \_\_\_\_\_

