Americans with Disabilities Act of 1990

STATEMENT OF GRIEVANCE

Name of Individual Making the Complaint: _____

Address: _____

City: _____ State: _____ Zip: _____

Day Telephone: _____ Evening Telephone: _____

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: _____

This section is for court use only

Date Filed: _____ Time Filed: _____

Complaint Taken By: _____
Staff Person's Name

Complainant's Law Name: _____

1. Name the court or court facility in which the violation is alleged to have occurred:

_____

2. Describe what happened that led to the decision to file this complaint. (If necessary, use an additional page to complete the statement).

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: _____

Complainant's Law Name: _____

Continued from Question Number: _____

If necessary, use an additional page to complete the statement.