AMERICANS WITH DISABILITIES ACT
COMPLAINT/GRIEVANCE FORM

Please print legibly.

Name:____

Address (City, State, Zip): ____

Telephone #: ____

Email Address: ____

Preferred Contact: ___Phone ___Email

Name of Person Discrimated Against (if different): ______________________________

Address: ____

Telephone: ____

Email Address: ____

Please provide a complete description of grievance including any locations or individuals involved. (Attach additional sheets if necessary)

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Please state what you think should be done to resolve the complaint or grievance:

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____
Signature of person completing the form Date

Return to: ADA Coordinator, Town of Cumberland, 11501 E. Washington St. Cumberland, IN 46229