Town of Sherman, CT ADA Complaint Form

Americans with Disabilities Act Complaint Form

Please complete this form. Fields marked with an asterisk (*) are required

Person filling out this form

First Name* _____________________ Middle ______________________

Last Name*________________________ Suffix________

Address*____

City*________________________________ State*______________Zip*____________

Telephone*____________________________ Email*____________________________

Concerned Person(s) (if other than the complainant)

____

Incident (if a particular incident) or Problem

Government, organization, institution or business which you believe has discriminated

Name *____

Address____

City *____________________________________State *_________________ Zip_________

Telephone Number___________________________________

When did the problem occur? Is it an ongoing issue?
Date_______________________________________

Primary type of disability involved with the complaint* (check all that apply)

Mobility __________ Vision __________ Hearing _________ Speech___________
Cognitive/intellectual/developmental __________ Learning _________ Diabetes_________
Mental/psychiatric_________ Seizure _________HIV/AIDS _________
Other or not listed_________

Problem or Issue with * (check all that apply)

employment __________ physical access __________ housing __________
interpreter/assistive listening __________ service animal __________ retaliation __________
denial of services/refusal to admit __________ other or don't know ___________

Describe the problem*

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Have efforts been made to resolve this complaint through the internal grievance procedure of the government, organization, institution or business? *
Yes_______ No_______

Has the complaint been filed with any other Federal, State or local civil rights agency or court? *
Yes________ No ________

Agency or Court

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