AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM

Today's Date: _____

Name of Grievant: _____

Address of Grievant: _____

Telephone Number of Grievant: _____

Name, Address, and Telephone Number of Alternate Contact Person:_____

_____

Agency alleged to have denied access:

Department: _____

Division: _____

Bureau or Office: _____

Location: _____

I was denied access on: _____[date]

Disability Statement:

My disability is:_____

_____

This problem is: temporary_____ permanent_____

I am seeking access to the following Harris County program or activity in which I haven't been able to participate because I need an accommodation:_____

Proposed Access or Accommodation:

The accommodation I seek:_____

_____

_____

Incident or Barrier:
Please describe the particular way in which you believe you have been denied the benefits of any services, program, or activity or have otherwise been subjected to discrimination. Please specify dates, times, and places of incidents, and names and/or positions of agency employees involved, if any, as well as names, addresses and telephone numbers of any eyewitnesses to any such incident. Attached additional pages if necessary. Include a description of the way in which you feel access may be had to the benefits described above, or the way in which accommodation could be provided to allow access.

_____

_____

_____

_____

Mail or Fax this form to:

ADA Coordinator
Harris County HR & RM
1310 Prairie, 2nd Floor
Houston, Texas 77002
713.755.2669 (Fax)