CITY OF SHELBYVILLE

INCORPORATED 1810
AMERICANS WITH DISABILITIES ACT (ADA) COORDINATOR
201 N. SPRING STREET
SHELBYVILLE, TN 37160

TEL: (931) 684-2691 FAX: (931) 684-1423
stacey.claxton@shelbyvilletn.org

GRIEVANCE FORM

I. COMPLAINANT INFORMATION

Name of Complainant: _____
Last MI First

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ E-mail Address: _____

Preferred Method(s) of Communication: (Check all that apply)

☐ Voice Telephone ☐ TTY ☐ E-mail ☐ US MAIL & ☐ Other: _____

II. DESCRIBE YOUR COMPLAINT OF DISCRIMINATION BASED UPON DISABILITY.

Be specific and give date(s), time(s) and location(s). Use the reverse side of this sheet or attached pages, if needed.

III. PERSONS NAMED IN YOUR COMPLAINT.

List the names of (or describe) all persons involved in your complaint. Indicate the job title and City Agency, department or division of City employees, if possible.

IV. WITNESSES TO YOUR COMPLAINT. List the names of (or describe) all persons involved in your complaint. Indicate the job title and City Agency, department or division of City employees, if possible.

V. <u>EVIDENCE AND DOCUMENTATION.</u> List and provide any physical evidence, written or recorded documents, or any other information that directly supports your specific claim of discrimination.

VI. <u>CASE REMEDY AND/OR RESOLUTION.</u> What remedies or resolutions are you seeking?

CERTIFICATION: I hereby certify that the information and statements above are true.

Signature: _____ Date: _____

If person needing accommodation is not the individual completing this form, please provide

Representative's Name: _____

Address: _____ Telephone Number: _____

For more information or assistance in completing the form, please contact the
ADA Coordinator via (direct line) (931) 684-2691 or
stacey.claxton@shelbyvilletn.org