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

VI. CASE REMEDY AND/OR RESOLUTION. 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@shelbyville tn.org