Town of Colma

AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM

NAME:_____ TODAY'S DATE: _____

ADDRESS: _____ E-MAIL:_____

PHONE NUMBER:_____ CELL PHONE:_____

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

_____

Department alleged to have denied access: _____

_____

Location: _____

I was denied access on: _____ (date)

Disability Statement:
My disability is: _____

_____

This problem is: _____(temporary) _____(permanent)

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

Proposed Access or Accommodation:_____

_____

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. Attach additional pages if necessary. Include a description of the way in which you feel access may be facilitated to the benefits described above or the way in which accommodation could be provided to allow access.

_____

_____

_____

Return this form to:

Sean Rabe', City Manager
1198 El Camino Real, Colma, CA 94014
650.997.8300; 650.997.8308 FAX
Sean.rabe@colma.ca.gov