City of O'Fallon
Grievance Form
Discrimination Based on Disability

It is the Policy of the City of O'Fallon to provide assistance in completing this form. If assistance is needed, please contact the Designated ADA Coordinator.

Name of Complainant:_____

Name of Complainant's Representative:_____

Complainant's Address:_____
Street

_____
City State Zip Code

Telephone Number:_____ _____
Home Cell

_____ _____
Work TDD

_____ _____
Representative's Phone Number(s)

Best time and means for contacting Complainant:_____

Best time and means for contacting Representative:_____

Program, service, or activity to which access was denied or in which alleged discrimination occurred:

_____

Nature of alleged discrimination:_____

_____

Date of alleged discrimination:_____ Today's Date:_____

Resolution requested: _____

I certify that I am qualified or otherwise eligible to participate in the program, service, or activity and the above statements are true to the best of my knowledge and belief.

Signature of Complainant:_____ **Date:**_____

Signature of Representative:_____ **Date:**_____