

ADA GRIEVANCE FORM

Complainant: _____

Address: _____

City, State and Zip Code: _____

Telephone: Home: _____ Business: _____

Person Discriminated Against:
(if other than the complainant) _____

Address: _____

City, State and Zip Code: _____

Telephone: Home: _____ Business: _____

Describe the acts of discrimination providing the name(s) where possible of the individuals who discriminated: _____

Date of when the discrimination occurred: _____

Has the complaint been filed with any other Federal, State or local civil rights agency or court? Yes _____ No _____

Signature: _____

Date: _____

Return to:
City of Whiting Board of Public Works and Safety
Attn: John Haynes
1443 119th Street
Whiting, IN 46394

Assistance in filling out the document is available by contacting Bob Kark at (219) 659 7700 extension 235. Individuals with hearing impairments may contact us through the Indiana Relay Service.

Requests for alternate formats please contact Bob Kark at (219) 659 7700 extension 235 or your bkark@whitingindiana.com . Individuals with hearing impairments may contact us through the Indiana Relay Service.