

## AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM

Today's Date: \_\_\_\_\_

Name of Grievant: \_\_\_\_\_

Address of Grievant: \_\_\_\_\_

Telephone Number of Grievant: \_\_\_\_\_

Name, Address, and Telephone Number of Alternate Contact Person: \_\_\_\_\_

\_\_\_\_\_

Agency alleged to have denied access:

Department: \_\_\_\_\_

Division: \_\_\_\_\_

Bureau or Office: \_\_\_\_\_

Location: \_\_\_\_\_

I was denied access on: \_\_\_\_\_ [date]

Disability Statement:

My disability is: \_\_\_\_\_

\_\_\_\_\_

This problem is: \_\_\_\_\_ temporary \_\_\_\_\_ permanent \_\_\_\_\_

I am seeking access to the following Harris County program or activity in which I haven't been able to participate because I need an accommodation: \_\_\_\_\_

Proposed Access or Accommodation:

The accommodation I seek: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 had to the benefits described above, or the way in which accommodation could be provided to allow access.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Mail or Fax this form to:

ADA Coordinator  
Harris County HR & RM  
1310 Prairie, 2nd Floor  
Houston, Texas 77002  
713.755.2669 (Fax)