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: ____________________

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Agency alleged to have denied access:

Department: ____

Division: ____

Office: ____

Location: ____

I was denied access on: _______________________________________ (date)

Disability Statement

My Disability is: ____

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The problem is: temporary ___________ permanent ______________

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

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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, time, 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.

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Mail or Fax this form to: ADA Coordinator, Galveston County Human Resources, 722 Moody, 3rd Floor, Galveston, TX 77550; Fax 409.770.5351, email to katherine.branch@co.galveston.tx.us