AMERICANS WITH DISABILITIES ACT
GRIEVANCE FORM

Grievant's Name:	Today's Date:
Address:	
Email Address:	
Telephone:	

IF YOU ARE A LEGALLY AUTHORIZED REPRESENTATIVE FILING THE GRIEVANCE ON BEHALF OF THE GRIEVANT, PLEASE COMPLETE YOUR CONTACT INFORMATION BELOW

Representative's Name:
Address:
Email Address:
Telephone:

Date of Incident:	Time of Incident:
Location/Address of Incident:	
Describe your Grievance:	
If the incident(s) involved City of Davis employees, list their name(s):	

If filing on behalf of another Person/Group, list their name:

State requested remedy to your grievance:
Complaint was filed with the US Department of Justice or other federal or state civil rights agency or court: ☐ YES ☐ NO If YES, list name of agency or court where the complaint was filed, date of filed complaint, name, address and telephone of contact person.

Grievant's Signature: Date:

Legally Authorized Representative Signature: Date:

Please fill out this form completely and sign and date before submitting to:
ADA Coordinator, 23 Russell Blvd., Davis, CA 95616 or
ADACoordinator@cityofdavis.org or call 530-757-5694