Title II of the Americans with Disabilities Act

COMPLAINT FORM

Instructions: Please fill out this form completely, in black ink or type. Sign and return to the address on page 2.

Complainant: ________________________________________________________________

Address: ___________________________________________________________________

City, State and Zip Code: ______________________________________________________

Telephone: Home: Business: ____________________________________________________

Person Making the Complaint: (if other than the complainant) ______________________

Address: ___________________________________________________________________

City, State, and Zip Code: ______________________________________________________

Telephone: Home: Business: ____________________________________________________

Department/Agency which you believe has discriminated:

Name: ______________________________________________________________________

Address: ___________________________________________________________________

County: _____________________________________________________________________

City: ______________________________________________________________________

State and Zip Code: ____________________________________________________________

Telephone Number: ___________________________________________________________

When did the event occur? Date: ________________________________________________

Describe the event providing the name(s) where possible for the individuals who were involved (use space on page 3 if necessary):

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Has the complaint been filed with the Michigan Department of Civil Rights or the Federal Department of Justice or any other Federal agency or court? Yes____ No____

If yes (Next page)
Agency or Court: ____________________________________________
Contact Person: ____________________________________________
Address: ________________________________________________
City, State, and Zip Code: __________________________________
Telephone Number: _______________________________________
Date Filed: ______________________________________________

Do you intend to file with another agency or court? Yes____ No____
Agency or Court: __________________________________________
Contact Person: __________________________________________
Address: ________________________________________________
City, State, and Zip Code: __________________________________

Additional space for answers:

Signature: ________________________________________________
Date: ____________________________________________________

Return to:
Brandon Gulnick
ADA Coordinator
100 Center Street
Pembroke, MA 02359
Phone: (781) 709 - 1416
Fax: (781) 293 - 4650