U.S. Department of Justice
Civil Rights Division
Disability Rights Section

OMB No. 1190-0009

Title II of the Americans with Disabilities Act
Section 504 of the Rehabilitation Act of 1973
Discrimination Complaint Form

Instructions: Please fill out this form completely, in black ink or type. Sign and return to the address on page 3.

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:

Government, or organization, or institution which you believe has discriminated:

Name:

Address:

County:

City:

State and Zip Code:

Telephone Number:

When did the discrimination occur? Date:

Describe the acts of discrimination providing the name(s) where possible of the individuals who discriminated (use space on page 3 if necessary):

Have efforts been made to resolve this complaint through the internal grievance procedure of the government, organization, or institution?

Yes_____ No_____

If yes: what is the status of the grievance?

Has the complaint been filed with another bureau of the Department of Justice or any other Federal, State, or local civil rights agency or court?

Yes_____ No_____

If yes:

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:

Address:

City, State and Zip Code:

Telephone Number:

Additional space for answers:

Signature: _____

Date: _____

Return to:

U.S. Department of Justice

Civil Rights Division
950 Pennsylvania Avenue, NW
Disability Rights - NYAV
Washington, D.C. 20530

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