TOWNSHIP OF MIDDLETOWN

AMERICANS WITH DISABILITIES ACT COMPLAINT FORM

COMPLAINANT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	
ADDRESS	CITY	STATE	ZIP
PHONE NUMBER Home: ( ) - Work (optional): ( ) -		DATE	

ALTERNATE CONTACT

LAST NAME	FIRST NAME	MIDDLE NAME	
ADDRESS	CITY	STATE	ZIP
PHONE NUMBER Home: ( ) - Work (optional): ( ) -			

COMPLAINT INFORMATION

AGENCY ALLEGED TO HAVE DISCRIMINATED / DENIED ACCESS	
DIVISION / UNIT	
LOCATION (City / County)	DATE OF INCIDENT
INCIDENT OR BARRIER	

Please describe in detail the alleged barrier or discriminatory conduct alleged to have occured.

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