TOWNSHIP OF MIDDLETOWN

AMERICANS WITH DISABILITIES ACT COMPLAINT FORM



COMPLAINT INFORMATION AGENCY ALLEGED TO HAVE DISCRIMINATED / DENIED ACCESS DIVISION / UNIT LOCATION (City / County) DATE OF INCIDENT	COMPLAINANT INFORMATION				
PHONE NUMBER Home: () Work (optional): () DATE ALTERNATE CONTACT LAST NAME PIRST 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.	LAST NAME	FIRST NAME		MIDDLE NAME	
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