



CITY OF BUFFALO



**TITLE II AMERICANS WITH DISABILITIES ACT
DISABILITY DISCRIMINATION
COMPLAINT FORM**

Instructions: Please complete all parts of this form in black or blue ink or type. Sign, date, and return to the address on page 3.

PERSON DISCRIMINATED AGAINST:

NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE (H) _____ (W) _____

NATURE OF DISABILITY _____

INDIVIDUAL FILING COMPLAINT:

(COMPLETE ONLY IF THE COMPLAINT IS BEING FILED BY A PERSON OTHER THAN THE INDIVIDUAL DISCRIMINATED AGAINST)

NAME _____

TITLE _____

FIRM _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE (H) _____ (W) _____

ALLEGED DISCRIMINATION:

DATE OF DISCRIMINATION _____

LOCATION OF DISCRIMINATION _____

DESCRIBE THE ACTS OF DISCRIMINATION _____

STATE THE DESIRED REMEDY OR SOLUTION REQUESTED

LIST THE NAMES AND TELEPHONE NUMBERS OF WITNESSES WHO
CAN PROVIDE INFORMATION SUPPORTING YOUR COMPLAINT

witness name

witness phone #

1. _____
2. _____
3. _____

HAS THIS ACT OF DISCRIMINATION BEEN REPORTED TO ANY OTHER
STATE, LOCAL, OR FEDERAL ENTITY? _____

DO YOU REQUIRE AUXILIARY AIDS OR SERVICES TO ENSURE
EFFECTIVE COMMUNICATION DURING THE HEARING? _____

IF YES PLEASE DESCRIBE. _____

I HEREBY AFFIRM THAT THE ABOVE IS TRUE TO THE BEST OF MY
KNOWLEDGE

SIGNATURE _____ DATE _____

PRINT NAME _____

RETURN TO:

DELIA CADLE
ADA COORDINATOR
DEPUTY CORPORATION COUNSEL
CITY OF BUFFALO LAW DEPARTMENT
1100 CITY HALL
BUFFALO, NEW YORK 14202