Office of Disability Services and Resources
ADA APPEAL / COMPLAINT FORM

Name: _____ _____ A Number: _____

Address: _____ _____ City:_____ Zip: _____

Phone: _____ __ Cell Phone: _____ ____

Personal E-mail: _____ _____

Brief Description of the alleged acts of discrimination, the dates they occurred, and the names of individuals involved OR Brief Description of alleged acts of non - compliance , the dates they occurred and the names of individuals involved:

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PLEASE ATTACH ALL DOCUMENTATION NEEDED TO SUPPORT YOUR CLAIM.

List any witnesses and their contact information:

_____
_____
_____ __ _____
_____

Signature: _____ Date: _____ control

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