Title II of the Americans with Disabilities Act Discrimination/ Grievance Complaint Form

Instructions: Please fill out this form completely if you feel you or someone that has authorized you to act on their behalf has been discriminated against based on disability. You may submit your completed form in person, or to the mailing address or email address below:

Cindy Lyle, ADA Coordinator
404 West Palm Drive
Florida City, Fl 33034
305-242-8178
com-dev@floridacityfl.gov

Complainant: _____

Address: _____

Contact Phone Number: _____mobile:_____

Person discriminated against (if other than the complainant):

Name: _____

Address: _____

Contact Phone Number: _____mobile:_____

City of Florida Department which you believe has discriminated based on disability:

Department: _____

Address: _____

Has the Department received this complaint: _____yes _____ no

If yes, what date: _____

Have you filed a complaint with the Department of Justice or other agency?
_____yes _____no

If yes, name of agency and contact information with which the complaint was filed:

_____

_____

When did the discrimination occur? Date of incident_____

Describe the acts of discrimination providing the name(s) where possible of the individual(s) who discriminated based on disability:

_____

_____

_____

_____

Remedy sought:

_____

_____

_____

I confirm that 1) the information provided about the name of the person completing the form is correct, 2) The information provided in the description of the grievance section is, to the best of my knowledge, true and 3) if I completed this form on behalf of the person who was discriminated against, I am authorized to do so.

_____ _____

Signature Date