



**University City
Grievance Form
Discrimination based on Disability**



It is the Policy of the City of University City to provide assistance in completing this form. If assistance is needed, please contact the Designated ADA Coordinator.

Name of Complainant: _____

Name of Complainant's Representative: _____

Complainant's Address: _____
Street

City State Zip Code

Telephone Number: _____

Home

Cell

Work

TDD

Representative's Phone Number(s)

Best time and means for contacting Complainant: _____

Best time and means for contacting Representative: _____

Program, service, or activity to which access was denied or in which alleged discrimination occurred:

Nature of alleged discrimination: _____

Date of alleged discrimination: _____ Today's Date: _____

Resolution requested: _____

I certify that I am qualified or otherwise eligible to participate in the program, service, or activity and the above statements are true to the best of my knowledge and belief.

Signature of Complainant: _____ Date: _____

Signature of Representative: _____ Date: _____