



AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM

GRIEVANT'S NAME: _____ TODAY'S DATE: _____
ADDRESS: _____
EMAIL ADDRESS: _____
TELEPHONE: _____ WORK: _____ CELL: _____

**IF A LEGALLY AUTHORIZED REPRESENTATIVE IS FILING THE GRIEVANCE ON YOUR BEHALF,
THEIR NAME, ADDRESS AND TELEPHONE NUMBER MUST ALSO BE INCLUDED.**

REPRESENTATIVE'S NAME: _____
ADDRESS: _____
EMAIL ADDRESS: _____
TELEPHONE: _____ WORK: _____ CELL: _____
DATE OF INCIDENT: _____ TIME OF INCIDENT: _____ AM / PM
LOCATION/ADDRESS OF INCIDENT: _____

DESCRIBE YOUR GRIEVANCE: _____

IF THE INCIDENT(S) INVOLVED CITY OF MISSION VIEJO EMPLOYEE(S), THEIR NAME(S): _____

NAME(S) AND CONTACT INFORMATION OF WITNESSES: _____

**IF YOUR GRIEVANCE IS BEING FILED ON BEHALF OF ANOTHER PERSON OR GROUP,
ALL OF THE GRIEVANT(S) SHOULD BE DESCRIBED OR IDENTIFIED BY NAME, IF POSSIBLE:**

PERSON/GROUP NAME: _____

STATE REQUESTED REMEDY TO YOUR GRIEVANCE: _____

GRIEVANT'S SIGNATURE DATE

LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE DATE