CITY OF MISSION VIEJO

200 CIVIC CENTER MISSION VIEJO, CALIFORNIA 92691



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 NA	ME:		
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 CONTA	CT 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 NAM	E:		
STATE REQUESTED RE	MEDY TO YOUR GRIEVANCE:		
GRIEVANT'S SIGNATU	RE		DATE
LEGALLY AUTHORIZED	REPRESENTATIVE SIGNATURE		DATF

Please fill out this form completely in blue or black ink or type. Sign, date and return to: **Heather Campbell, ADA Title II and Section 504 Compliance Officer, 200 Civic Center, Mission Viejo, CA. 92691.** (Attach additional sheets as necessary.)