Title II of the Americans with Disabilities Act  
Section 504 of the Rehabilitation Act of 1973  
Discrimination Complaint Form

Instructions: Please fill out this form completely, in black ink or type. Sign and return to the address on page 3.

Complainant: __________________________________________

Address: ______________________________________________

City, State and Zip Code: ____________________________________

Telephone: Home: ____________________________

Business: ____________________________

Person Discriminated Against: ____________________________
(if other than the complainant)

Address: ______________________________________________

City, State, and Zip Code: ____________________________________

Telephone: Home: ____________________________

Business: ____________________________

Government, or organization, or institution which you believe has discriminated: ____________________________

Name: ____________________________
Address: ________________________________________________________________

County:__________________________________________________________________

City: ___________________________________________________________________

State and Zip Code: _______________________________________________________

Telephone Number: _______________________________________________________

When did the discrimination occur? Date: ________________________________

Describe the acts of discrimination providing the name(s) where possible of the individuals who discriminated (use space on page 3 if necessary):
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Have efforts been made to resolve this complaint through the internal grievance procedure of the government, organization, or institution?

Yes______ No______

If yes: what is the status of the grievance?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Has the complaint been filed with another bureau of the Department of Justice or any other Federal, State, or local civil rights agency or court?

Yes______ No______

If yes:

Agency or Court: ________________________________________________________
Contact Person: 

Address: 

City, State, and Zip Code: 

Telephone Number: 

Date Filed: 

Do you intend to file with another agency or court? 

Yes______ No______

Agency or Court: 

Address: 

City, State and Zip Code: 

Telephone Number: 

Additional space for answers:

________________________________________

________________________________________

________________________________________

________________________________________

Signature: ________________________________

Date: ________________________________

Return to:

U.S. Department of Justice 
Civil Rights Division 
950 Pennsylvania Avenue, NW 
Disability Rights - NYAV 
Washington, D.C. 20530 

last updated October 3, 2007