

AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM

Today's Date: _____

Name of Grievant: _____

Address of Grievant: _____

Telephone Number of Grievant: _____

Name, Address and Telephone Number of Alternate Contact Person:

Agency alleged to have denied access:
City of Troy Administration Office, 116 E. Market St., Troy, IL 62294

I was denied access on: _____ (date)

Disability Statement

My disability is: _____

This problem is: temporary _____ Permanent _____

I am seeking access to the City of Troy which I haven't been able to enter because I need an Accommodation:

Proposed Access or Accommodation:

The accommodation I seek:

Incident or Barrier:

Please describe the particular way in which you believe you have been denied the benefits of any services, program or activity or have otherwise been subjected to discrimination. Please specify dates, times and places of incidents and name and/or positions of agency employees involved. If any, as well as names, addresses and telephone numbers of any eyewitnesses to any such incident. Attach additional pages if necessary. Include a description of the way in which you feel access may be had to the benefits described above, or the way in which accommodation could be provided to allow access.

MAIL OR FAX THIS FORM TO 618-667-4009

ADA Coordinator
DeeAnne Byrne-Scott
City of Troy
116 E. Market St.
Troy, IL 62294