Office of Disability Services and Resources
ADA APPEAL / COMPLAINT FORM

Name: ______________________ ________________ A Number: _______________

Address: ________________________ _____ City:_________________ Zip: ______

Phone: _____________________ __ Cell Phone: _________________________ ____

Personal E-mail: _____ ____

Brief Description of the alleged acts of discrimination, the dates they occurred, and the names of individuals involved OR Brief Description of alleged acts of non-compliance, the dates they occurred and the names of individuals involved:

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PLEASE ATTACH ALL DOCUMENTATION NEEDED TO SUPPORT YOUR CLAIM.

List any witnesses and their contact information:

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Signature: ___________________________________ Date: _______________ control

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