CITY OF SANFORD
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:

Department: _____

Division: _____

Location: _____

I was denied access on: _____[date]

Disability Statement:

My disability is:_____

_____

This problem is: temporary_____ permanent_____

I am seeking access to the following City of Sanford program or activity in which I haven't been able to participate 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 names and/or positions of City 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.

_____

_____

_____

_____

Fax this form to 919-774-8712 or email to Van Dowdy at van.dowdy@sanfordnc.net or mail to:

Van Dowdy
Risk Manager
City of Sanford
PO Box 3729
Sanford NC 27331-3729
919-777-1132