



**EMPLOYEE COMPLAINT OF DISCRIMINATION  
ON THE BASIS OF DISABILITY  
CLAIM FORM**

Identity of individual who believes he/she has been discriminated against on the basis of disability:

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Name	Address	Phone No.
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Have you authorized someone to file this complaint on your behalf?  
\_\_\_\_ Yes \_\_\_\_ No If yes, please provide the following information for the authorized representative:

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Name	Address	Phone No.
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Please describe the alleged discriminatory action in enough detail so that the nature of your complaint can be clearly understood:

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Please give the date(s), time(s), and location(s) of the incident(s):

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If the incident(s) involved a City employee(s), please provide his or her name(s) and/or badge number(s), if you know this information:

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Please give the name(s) and address(es), if known, of any witnesses to the alleged discrimination:

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If this complaint is filed on behalf of a group of people or on behalf of a third person, please provide the names and addresses of all of the victims of the alleged discrimination, if possible:

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What action do you want taken to correct the alleged discrimination?

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Is there any other information you want the City to know concerning your discrimination claim?

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Signature of (check one)

Victim of alleged discrimination

Authorized representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date