MADISON COUNTY, INDIANA AMERICANS WITH DISABILITIES ACT
TITLE II: GRIEVANCE FORM

Date: _____

Person Filing Complaint: _____
Address: _____
City, State, Zip: _____
Telephone: _____
E-mail: _____

Individual Discriminated Against: _____
Address: _____
Address: _____
City, State, Zip: _____
Telephone: _____
E-mail: _____

Alleged Violation:
Date(s) of Occurrence: _____
Description of Violation: _____
_____
_____
_____
_____
_____
_____
_____
_____
Department Involved: _____
Location of Violation: _____

Requested Action by County to Correct Violation: _____
_____
_____
_____
_____
_____

Has Complaint been Filed with State or Federal Agency: ☐ Yes ☐ No.
Name of Agency: _____ Date Filed: _____
Contact Person: _____ Telephone: _____

Signature: _____