



# City of Henderson Americans with Disabilities Act Grievance Form

**Instructions:** Please PRINT or TYPE this form and submit to: ADA/504 Coordinator, City of Henderson, Department of Human Resources, PO Box 95050, Henderson, NV 89009. Hours of operation: Monday-Thursday, from 7:30 am to 5:30 pm (PST): (702) 267-1914 (voice), 7-1-1 (TTY), (702) 267-1902 (fax) or email: robert.osip@cityofhenderson.com

**NAME OF GRIEVANT:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number:  
Home \_\_\_\_\_ Cell \_\_\_\_\_ Other: \_\_\_\_\_

**Person Preparing Complaint (If different from Grievant):**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number:  
Home \_\_\_\_\_ Cell \_\_\_\_\_ Other: \_\_\_\_\_  
Relationship of Preparer to Grievant (if applicable): \_\_\_\_\_

**NATURE OF GRIEVANCE:**

Date of Incident: _____	Location: _____
-------------------------	-----------------

My disability is: \_\_\_\_\_

Please describe the nature of the specific complaint or grievance, including any incident, barrier, or perceived denial of benefits of any service, program or activity, or have otherwise been discriminated against because of, or related to, a disability. (If necessary, use additional pages or attachments to substantiate your description):

**PROPOSED RESOLUTION OR ACCOMMODATION:**

Please describe what you believe should be done to resolve the grievance.

\_\_\_\_\_  
Signature of Grievant/Preparer

\_\_\_\_\_  
Date

If you need assistance completing this form or need this form in an alternative format, contact the ADA/504 Coordinator.

Individuals may also file a grievance directly to: U.S. Dept. of Justice, Civil Rights Division, 950 Pennsylvania Avenue, NW, Disability Rights Section – NYAV, Washington, DC 20530, (800) 514-0301(voice), (800) 514-0383 (TTY), or [www.ada.gov](http://www.ada.gov)