COUNTY OF KALAMAZOO
Americans with Disabilities Act
Grievance Form

PRINT

Please provide the following information:

1. Name:_____

   Address:_____

   City:_____ State:_____ Zip Code: _____

   Home Phone:_____ Cell Phone:_____

   E-Mail address:_____

2. Date the aggrieved action occurred or was observed:_____

3. Name and location of the County program or service involved that is the subject of the complaint.

   Name of program or service:_____

   Address:_____

   City:_____ State:_____ Zip Code: _____

4. Name(s) of the County employee representative with whom you made contact regarding the subject of this grievance:

   _____

   _____

5. Describe why you believe you are the victim of discrimination on the basis of disability in the delivery of County programs and services.

   _____

   _____

   _____

_____ _____

Signature of Grievant Date

When you have completed this request, please return it to the County by printing thisform and drop off at any County office or send to ADA Coordinator, Kalamazoo County Administrator, 201 W. Kalamazoo Ave., Kalamazoo MI 49007 or by calling 269.384.8111.