



## **Title II of the Americans with Disabilities Act Discrimination/ Grievance Complaint Form**

Instructions: Please fill out this form completely if you feel you or someone that has authorized you to act on their behalf has been discriminated against based on disability. You may submit your completed form in person, or to the mailing address or email address below:

Cindy Lyle, ADA Coordinator  
404 West Palm Drive  
Florida City, Fl 33034  
305-242-8178  
com-dev@floridacityfl.gov

Complainant: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ mobile: \_\_\_\_\_

Person discriminated against (if other than the complainant):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ mobile: \_\_\_\_\_

City of Florida Department which you believe has discriminated based on disability:

Department: \_\_\_\_\_

Address: \_\_\_\_\_

Has the Department received this complaint: \_\_\_\_\_yes \_\_\_\_\_ no

If yes, what date: \_\_\_\_\_

Have you filed a complaint with the Department of Justice or other agency?

\_\_\_\_\_yes \_\_\_\_\_no

If yes, name of agency and contact information with which the complaint was filed:

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When did the discrimination occur? Date of incident \_\_\_\_\_

Describe the acts of discrimination providing the name(s) where possible of the individual(s) who discriminated based on disability:

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Remedy sought:

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I confirm that 1) the information provided about the name of the person completing the form is correct, 2) The information provided in the description of the grievance section is, to the best of my knowledge, true and 3) if I completed this form on behalf of the person who was discriminated against, I am authorized to do so.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date