CITY OF KNOXVILLE
AMERICANS WITH DISABILITIES ACT COMPLAINT FORM

Please type or print this form in its entirety, including a detailed description of the discriminatory action(s) for which you are requesting relief. Additionally, you must provide a detailed description of the relief you are requesting. This form should be completed within ten (10) days of the occurrence of the alleged discriminatory action(s). When the form has been completed, please return it to the Director/Dept. Head responsible for the resolution of this problem, or, if the appropriate Director is unknown, return the form to the Disability Services Office Suite 539, P.O. Box 1631, Knoxville, TN. 37901. You may also fax to (865) 215-4581 or email to SCook@KnoxvilleTN.gov

1. _____ _____
   FULL NAME — LAST FOUR DIGITS SOCIAL SECURITY NUMBER

2. _____
   P.O. BOX OR STREET — CITY — STATE — ZIP

3. PHONE NUMBER: _____ _____
   HOME — WORK

4. Describe the nature of your disability:

5. Please list the action(s) taken by the City of Knoxville, which you believe to be discriminatory:

6. Please list any witnesses to this action(s) along with their contact information:

7. Please describe the relief or accommodation you are requesting:

Dir./Dept. Head Signature _____ Date _____

cc: ADA Coordinator
Complainant

Instructions for completing Americans with Disabilities Act Complaint Form

1 – 3 Self-explanatory

4. In your own words, describe your disability.

5. In your own words, describe your complaint.

6. If anyone witnessed the incident, write his/her name (include address and phone number if possible).

7. Tell what you would like the City of Knoxville to do about your complaint.

When you have completed this form, return it to the appropriate Director/Department Head or the Americans with Disabilities Act Coordinator.