ADA COMPLAINT FORM

acog

The Association of Central Oklahoma Governments is committed to ensuring that no person is excluded from participation in or denied the benefits of its services on the basis of disability as provided by the Americans with Disabilities Act of 1990. ADA complaints must be filed within 180 calendar days from the date of the alleged discrimination.

OFFICE USE ONLY

DATE RECEIVED:

DATE OF FILING:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER: _____

EMAIL ADDRESS: _____

INDICATE THE PERSON(S) WHO YOU BELIEVE DISCRIMINATED AGAINST YOU:

NAME(S): _____

WORK LOCATION (IF KNOWN): _____

WORK PHONE: _____

DATE OF ALLEGED INCIDENT: _____

IF YOU HAVE AN ATTORNEY REPRESENTING YOU CONCERNING THE MATTERS RAISED IN THIS COMPLAINT, PLEASE PROVIDE THE FOLLOWING:

NAME: _____

ADDRESS: _____

WORK PHONE: _____

EMAIL ADDRESS: _____

EXPLAIN WHY YOU BELIEVE DISCRIMINATION HAS OCCURRED. BE SURE TO INCLUDE HOW OTHER PERSONS WERE TREATED DIFFERENTLY THAN YOU. IF THERE ARE WITNESSES, PLEASE PROVIDE NAMES, ADDRESSES, AND TELEPHONE NUMBERS. ATTACH ADDITIONAL PAGES AS NECESSARY AND ANY WRITTEN MATERIAL PERTAINING TO YOUR CASE.

WHAT REMEDY ARE YOU REQUESTING? **PLEASE BE SPECIFIC**:

HAVE YOU FILED OR DO YOU INTEND TO FILE A CHARGE OR COMPLAINT CONCERNING THE MATTERS RAISED IN THIS COMPLAINT WITH ANY OTHER AGENCIES (FEDERAL, STATE, OR LOCAL): YES ☐ NO ☐

IF SO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

AGENCY: _____

ADDRESS: _____

NAME OF INVESTIGATOR (IF KNOWN): _____

PHONE NUMBER: _____

EMAIL ADDRESS: _____

DATE FILED: _____

STATUS OF CASE: _____

I CONFIRM THAT I HAVE READ THE ABOVE CHARGE(S) AND IT IS TRUE TO THE BEST OF MY KNOWLEDGE.

PRINT OR TYPED NAME OF COMPLAINANT:

SIGNATURE: _____ **DATE:** _____

COMPLETED FORMS MUST BE SUBMITTED TO THE ASSOCIATION OF CENTRAL OKLAHOMA GOVERNMENTS. IF YOU REQUIRE ANY ASSISTANCE, PLEASE CONTACT THE TITLE VI COORDINATOR AT 405-234-2264 or title.vi@acogok.org