AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM

Date: _____

Name of Grievant: _____

Address of Grievant: _____

Telephone Number(s): _____

Name, Address, and Contact Number of Alternate Contact Person: _____

_____

Department/Division alleged to have denied access:

Department: _____

Division: _____

Location: _____

I was denied access on: _____(date)

Disability Statement:

My Disability is: _____

_____

The problem is: temporary_____ permanent_____

I am seeking access to the following City of Columbia program or activity in which I haven't been able to participate because I need an accommodation: _____

_____

Proposed Access or Accommodation:

The accommodation I seek: _____

_____

Incident or Barrier:

Please describe the particular way in which you believe you have been denied the benefits of any services, program, or activity or have otherwise been subjected to discrimination. Please specify dates, times, and places of incidents, and names and/or positions of City employees involved, if any, as well as names, addresses and telephone numbers of any eyewitnesses to any such incident. Attach additional pages, if necessary. Include a description of the way in which you feel access may be had to the benefits described above, or the way in which accommodation could be provided to allow access.

_____

_____

_____

_____

Email this form hr@columbiasc.gov or mail to:

City of Columbia

Human Resources Department

1401 Main Street, 4th Floor

Columbia, SC 29201