TITLE II AMERICANS WITH DISABILITIES ACT
DISABILITY DISCRIMINATION
APPEAL FORM

Instructions: Please complete all parts of this form in black or blue ink or type. Sign, date, and return to the address on page 3.

PERSON DISCRIMINATED AGAINST:

NAME ________________________________________________________________

ADDRESS _____________________________________________________________

CITY ____________________ STATE ________________ ZIP ________________

TELEPHONE (H) ____________________ (W) ____________________

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INDIVIDUAL FILING APPEAL:
(COMPLETE ONLY IF THE APPEAL IS BEING FILED BY A PERSON OTHER THAN THE INDIVIDUAL DISCRIMINATED AGAINST)

NAME ________________________________________________________________

TITLE ________________________________________________________________

FIRM ________________________________________________________________
ADDRESS __________________________________________________________

CITY ________________________________________________________________

STATE_________________________________________ ZIP_____________________

TELEPHONE (H)_________________________________________ (W)___________

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APPEAL:
LOCATION WHERE DISCRIMINATION OCCURRED _________________________

DATE ORIGINAL COMPLAINT FILED _____________________________________

DATE OF HEARING ____________________________________________________

DATE OF DECISION ____________________________________________________

LIST THE NAMES AND TELEPHONE NUMBERS OF WITNESSES WHO CAN PROVIDE INFORMATION SUPPORTING YOUR COMPLAINT

witness name   witness phone #

1. ________________________________________________________________

2. ________________________________________________________________

3. ________________________________________________________________

IN YOUR OWN WORDS BRIEFLY EXPLAIN THE WRITTEN DECISION REGARDING THE ORIGINAL COMPLAINT ________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Page 2 of 3
WHY ARE YOU APPEALING THE DECISION?

__________________________________________________________

__________________________________________________________

STATE THE DESIRED REMEDY OR SOLUTION REQUESTED

__________________________________________________________

__________________________________________________________

DO YOU REQUIRE AUXILIARY AIDS OR SERVICES TO ENSURE EFFECTIVE COMMUNICATION DURING THE HEARING? 

IF YES, PLEASE DESCRIBE

__________________________________________________________

I HEREBY AFFIRM THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

SIGNATURE_________________________________________ DATE ___________

PRINT NAME ____________________________________

RETURN TO:

DAVID RODRIGUEZ
ACTING CORPORATION COUNSEL
CITY OF BUFFALO LAW DEPARTMENT
65 NIAGARA SQUARE
1101 CITY HALL
BUFFALO, NEW YORK 14202