CITY OF BUFFALO

TITLE II AMERICANS WITH DISABILITIES ACT
DISABILITY DISCRIMINATION
COMPLAINT 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 ________________________________________________

STREET ADDRESS _______________________________________

CITY _______________________ STATE ________________ ZIP __________

TELEPHONE (H)_________________________ (W)____________________

NATURE OF DISABILITY _______________________________________

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

NAME _______________________________________________________

Page 1 of 3
TITLE

FIRM

ADDRESS

CITY __________________ STATE____________ ZIP________

TELEPHONE (H) ___________________ (W)_____________________

ALLEGED DISCRIMINATION:

DATE OF DISCRIMINATION ________________________________

LOCATION OF DISCRIMINATION __________________________

DESCRIBE THE ACTS OF DISCRIMINATION __________________

STATE THE DESIRED REMEDY OR SOLUTION REQUESTED 

_________________________________________________________________

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

<table>
<thead>
<tr>
<th>Witness name</th>
<th>Witness phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ___________________________</td>
<td>___________________________</td>
</tr>
<tr>
<td>2. ___________________________</td>
<td>___________________________</td>
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<tr>
<td>3. ___________________________</td>
<td>___________________________</td>
</tr>
</tbody>
</table>

HAS THIS ACT OF DISCRIMINATION BEEN REPORTED TO ANY OTHER STATE, LOCAL, OR FEDERAL ENTITY? ___________________________

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:

MELISSA L. HOFFMAN
ADA COORDINATOR
ASSISTANT CORPORATION COUNSEL
CITY OF BUFFALO LAW DEPARTMENT
1100 CITY HALL
BUFFALO, NEW YORK 14202