ADA Compliance Team
152 W. Cedar Street, Sequim, WA 98382
PH (360) 681-6605 adacompliance@sequimwa.gov

GRIEVANCE COMPLAINT FORM

Complainant Contact Information:

_____
Name

_____
Street address/City/State/Zip code

_____
Phone number (work, home, cell, or message phone)

_____
Email address

Representative contact information (if needed):

_____
Name

_____
Street address/City/State/Zip code

_____
Phone number (work, home, cell, or message phone)

_____
Email address

_____
Relationship to aggrieved party

Name of respondent: City of Sequim, Washington

Department or agency (if known): _____

_____

Address/location (if known): _____

Date(s) of incident: _____

I believe the above actions were taken because of my disability. My primary type of disability is:

_____ (e.g., mobility, vision, developmental)

Statement of Complaint- How were you discriminated against? Explain as clearly as possible what happened, who was involved, and where it happened. Include all facts upon which the complaint is based. Attach additional sheets if needed.

_____

_____

_____

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_____

Name, position, and department of City employee you have contacted regarding the incident(s).

_____

_____

Witness or other involved – Provide name, address, telephone number, and email address (if available). Attach additional sheets if needed.

_____

_____

_____

_____

In the complainant's view, what would be the best way to resolve this grievance?

_____

_____

_____

_____

I certify under penalty of perjury of law that the information above is true and correct. I understand that all information becomes a matter of public record after the filing of this complaint.

_____ _____

Signature **Date**

_____ _____

Representative signature (if any) **Date**