Appendix D: COMPLAINT FORM

Name _____

Address _____**City**_____ **Zip** _____

Telephone: Home _____ **Work** _____ **Cell** _____

Basis of Complaint: (place checkmark}

Race
Color
Sex
National Origin
Age
Disability

Type of Complaint (place checkmark)

Program **Service** **Benefit** **Activity**

Who allegedly discriminated against you?

Name_____

Address _____ **City**_____ **Zip** _____

Telephone _____

If an organization what is its name?

Name of Organization_____

Address _____**City**_____ **Zip** _____

Telephone _____

Name of Contact_____

How were you discriminated against?

Dates and times discrimination occurred.

Were there any other witnesses to the discrimination?

Name	Title	Work Phone	Home Phone

Have you filed your complaint with anyone else?

Who_____

When _____

Do you have an Attorney in this matter?

Name _____

Address_____**City**_____**Zip** _____

When did you acquire _____

Signed _____ **Date** _____

Mail to: **Gail Walker, Mobility Manager**
c/o The Arc Chemung-Schuyler
203 12th Street
Watkins Glen, NY 14891
p. 607-535-3555