Rec'd By:_____
Date:_____

GRIEVANCE FORM

City of Mount Vernon, Indiana

INSTRUCTIONS: Please fill out this form completely in blue or black ink or type. Submit as directed in the Grievance Policy. Assistance filling out the form will be made available upon request.

Grievant Name:_____

Address:_____ email:_____

Home Telephone:_____ Cell:_____

If a representative is filing this grievance on behalf of another person, his/her personal information must also be included:

Representative Name:_____

Address:_____ email:_____

Home Telephone:_____ Cell:_____

City Dept. that you believe has discriminated: _____

Date and Time of the alleged discrimination: _____

Location or Address of alleged discrimination: _____

Describe your grievance and the nature of your disability. Please provide the name(s) of the individuals who allegedly discriminated against you, or list the City facilities you feel are in violation of the ADA:

_____

_____

_____

Names and contact information of witnesses: _____

_____

_____

What type of corrective action would you like to see taken? _____

_____

_____

Has the grievance been filed with another agency of the Local, State or Federal Government? _____

If yes, please indicate which agency: _____

_____ _____

Grievant or Representative Signature **Date**

Form Prepared By:_____ **Witnessed By:**_____