



104 Monroe Street Suite 2
Delta, Ohio 43515

Americans with Disabilities Act Discrimination and Complaint Form

Please complete this form. Fields marked with an asterisk (*) are required. If you wish to send attachments, you may do so after submitting this form. You will receive a response email after you have submitted this form that will contain a complaint reference number and instructions on how you may send attachments.

Person filling out this form

First Name * _____

Middle _____

Last Name * _____

Suffix _____

Address * _____

City * _____

State *

ZIP * _____

Telephone * (preferred) _____

Email * _____

Person(s) discriminated against (if other than the complainant):

Relationship: _____

Date of the occurrence: _____

Primary type of disability *

Issue *

Describe the issue and/or act(s) of discrimination *

4000 characters remaining.

Have any previous efforts been made to resolve this complaint? *

Yes

No

If yes, please describe below.

4000 characters remaining.

This form may be submitted directly online, or copied and mailed to our office (Attn: Program Director). The form may also be submitted by phone by calling 419-822-3556 and asking to speak with the Program Director. Once the complaint has been thoroughly investigated you will receive a confirmation of the resolution to this matter.

Thank you in advance for bringing this matter to our attention.