Chisago County
Americans with Disabilities Act
Grievance Form

COMPLAINANT INFORMATION

Name: _____

Address: _____ Apt. No.: _____

City: _____ State: _____ ZIP Code: _____

Telephone: _____ Other Phone: _____

E-mail: _____

AGGRIEVED INDIVIDUAL (IF OTHER THAN COMPLAINANT)

Name: _____

Address: _____ Apt. No.: _____

City: _____ State: _____ ZIP Code: _____

Telephone: _____ Other Phone: _____

E-mail: _____

NATURE OF THE COMPLAINT

County Department Involved: _____

Date(s) of Occurrence: _____

Description of Violation:

Requested Action of County to Correct Alleged Violation:

HAS THE COMPLAINT BEEN FILED WITH ANOTHER BUREAU OF THE DEPARTMENT OF JUSTICE OR ANY OTHER FEDERAL, STATE, OR LOCAL CIVIL RIGHTS AGENCY OR COURT?

Yes __ __ No _ _

IF YES

Date Filed: _____ Agency or Court: **_____ Contact Person**: **_____**
Telephone: _____ Address: _____
Apt.: _____ City: _____ State: _____
Zip Code: _____

IF NO

Do you intend to file with another agency or court? Yes_ _ No_ _

If **Yes: Agency or Court**: **_____**
Contact Person: **_____ Telephone: _____**
Address: _____ Apt.: _____
City: _____ State: _____ Zip Code: _____

ADDITIONAL COMMENTS

Signature: **_____ Date: _____**

Return to: Human Resources Director / ADA Compliance Director
Chisago County Government Center
313 N Main St, Suite 170
Center City, MN 55012
Telephone: **(651) 213-8830 Fax**: **(651) 213-8876**