ADA TITLE II GRIEVANCE FORM

I. COMPLAINANT INFORMATION

Full Name: _____

Address: _____

Phone: _____ Email: _____

II. DESCRIBE YOUR COMPLAINT OF DISCRIMINATION ON THE BASIS OF DISABILITY.

Provide a detailed description of the incident or condition, location, date, and time. Attach pages as needed.

III. CITY OF LONG BEACH EMPLOYEES.

List the names of any City of Long Beach employees involved in your grievance and how they are involved. Include job title and department if known.

IV. OTHERS INVOLVED.

List the names of all other persons involved in your grievance and how they are involved. Include contact information if known.

V. **EVIDENCE AND DOCUMENTATION.** List and provide any evidence or information that directly supports your specific claim of discrimination. Such evidence or information may include, but is not limited to, written or recorded documents, photos, and statements.

VI. **REMEDY OR RELIEF SOUGHT.** What remedies or relief are you seeking?

Signature of Complainant: _____ **Date:** ____/____/____

If form completed by person other than the complainant, please provide the following:

Name: _____ **Phone:** _____

For more information or assistance with completing this form, please contact the Citywide Accessibility Coordinator at (562) 570-6257 or jennifer.kumiyama@longbeach.gov.

Submit completed form via email or mail to:

Jennifer Kumiyama
City of Long Beach, Citywide Accessibility Coordinator
411 W Ocean Blvd, 10th fl, Long Beach, CA 90802
jennifer.kumiyama@longbeach.gov