

## ADA COMPLAINT FORM

If you have a complaint about the accessibility of our transit system or believe you have been discriminated against because of your disability, you can use this form to file a complaint. Please provide all facts and circumstances surrounding your issue or complaint so we can fully investigate the incident.

Please mail or return this form to: John Logan  
Director of Grants & Public Transit  
101 S Duke Street  
LaFayette, GA 30728  
j.logan@walkerga.us

<b>1. Complainant's name:</b>		
Address:		
City:	State:	Zip Code:
Daytime telephone: (     )		
E-mail address:		
Do you prefer to be contacted via e-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>2. Are you filing this complaint on your own behalf?</b>		
<input type="checkbox"/> Yes If YES, please go to question 6. <input type="checkbox"/> No If NO, please go to question 3.		
<b>3. Please provide your name and address.</b>		
Name of person filing complaint:		
Address:		
City:	State:	Zip Code:
Daytime telephone: (     )		
E-mail address:		
Do you prefer to be contacted via e-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>4. What is your relationship to the person for whom you are filing the complaint?</b>		
<b>5. Please confirm that you have obtained the permission of the aggrieved party to file a complaint on their behalf.</b>		
<input type="checkbox"/> Yes, I have permission. <input type="checkbox"/> No, I do not have permission		
<b>6. I believe that the discrimination I experienced was based on</b> (check all that apply)		
<input type="checkbox"/> Accessibility issue <input type="checkbox"/> Discrimination based on disability <input type="checkbox"/> Other		

<b>7. Date of alleged discrimination</b> (Month, Day, Year):
<b>8. Where did the alleged discrimination take place?</b>
<b>9. Explain as clearly as possible what happened and why you believe that you were discriminated against.</b> Describe all of the persons that were involved. Include the name and contact information of the person(s) who discriminated against you (if known). <i>Use the back of this form or separate pages if additional space is required.</i>
<b>10. Please list any and all witnesses' names and phone numbers/contact information.</b> <i>Use the back of this form or separate pages if additional space is required.</i>
<b>11. What type of corrective action would you like to see taken?</b>
<b>12. Have you filed a complaint with any other federal, state, or local agency, or with any federal or state court?</b> <input type="checkbox"/> Yes If yes, check all that apply. <input type="checkbox"/> No  <input type="checkbox"/> Federal Agency (List agency's name) <input type="checkbox"/> Federal Court (Please provide location) <input type="checkbox"/> State Court <input type="checkbox"/> State Agency (Specify agency) <input type="checkbox"/> County Court (Specify court and county) <input type="checkbox"/> Local Agency (Specify agency)

**13. Please provide information about a contact person at the agency/court where the complaint was filed.**

Name:	Title:	
Agency:	Telephone: (    )	
Address		
City:	State:	Zip Code:

You may attach any written materials or other information that you think is relevant to your complaint.

Signature and date is required:

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

If you completed Questions 3, 4 and 5, your signature and date is required

\_\_\_\_\_

Signature

\_\_\_\_\_

Date