

**Title II of the Americans with Disabilities Act  
Section 504 of the Rehabilitation Act of 1973  
Grievance Form**

Complainant: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business/Cell Phone: \_\_\_\_\_

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*This section to be completed only if aggrieved person is not the individual completing this form.*

Person Discriminated Against:  
(if other than the Complainant) \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business/Cell Phone: \_\_\_\_\_

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Program/Facility Alleged to be Inaccessible: \_\_\_\_\_

When did the situation occur: \_\_\_\_\_

Describe the situation or way in which the program is not accessible, providing the name(s) where possible of the individuals or department who were involved in the situation.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Have efforts been made to resolve this complaint through the Request of Accommodation with the ADA Coordinator?      YES              NO

If yes, what were the results? \_\_\_\_\_

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Additional Space for Answers: \_\_\_\_\_

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Send To:  
Charlotte County Board of County Commissioners  
ADA Coordinator  
18500 Murdock Circle  
Suite 131  
Port Charlotte, Florida 33948