



AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM

GRIEVANT'S NAME: _____ TODAY'S DATE: _____

ADDRESS: _____

EMAIL ADDRESS: _____

TELEPHONE: _____ WORK: _____ CELL: _____

**IF A LEGALLY AUTHORIZED REPRESENTATIVE IS FILING THE GRIEVANCE ON YOUR BEHALF,
HIS/HER NAME, ADDRESS AND TELEPHONE NUMBER MUST ALSO BE INCLUDED.**

REPRESENTATIVE'S NAME: _____

ADDRESS: _____

EMAIL ADDRESS: _____

TELEPHONE: _____ WORK: _____ CELL: _____

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____ AM / PM

LOCATION/ADDRESS OF INCIDENT: _____

DESCRIBE YOUR GRIEVANCE: _____

IF THE INCIDENT(S) INVOLVED CITY OF MISSION VIEJO EMPLOYEE(S), HIS/HER NAME(S): _____

NAME(S) AND CONTACT INFORMATION OF WITNESSES: _____

**IF YOUR GRIEVANCE IS BEING FILED ON BEHALF OF ANOTHER PERSON OR GROUP,
ALL OF THE GRIEVANT(S) SHOULD BE DESCRIBED OR IDENTIFIED BY NAME, IF POSSIBLE:**

PERSON/GROUP NAME: _____

STATE REQUESTED REMEDY TO YOUR GRIEVANCE: _____

GRIEVANT'S SIGNATURE

DATE

LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE

DATE