TOWN OF HAVERSTRAW

AMERICANS WITH DISABILITIES ACT DISCRIMINATION COMPLAINT FORM

Person filling out this form

Date_____

Last Name_____**First Name**_____**Middle**_____**Suffix**_____

Address_____

Telephone_____**Email**_____

Person(s) Discriminated Against (if other than complainant)

Name **Address** **Telephone**

Discriminatory Incident

Government, organization, institution or business which you believe has discriminated

Name_____

Address_____

When did the discrimination occur?

Date_____

Describe the act(s) of discrimination providing the name(s) where possible of the individual(s) who discriminated:

_____

_____

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Please submit this form to Michael Gamboli, ADA Coordinator and Director of Finance at mgamboli@townofhaverstraw.org or fax to 845-429-4701