

TOWN OF HAVERSTRAW

AMERICANS WITH DISABILITIES ACT DISCRIMINATION COMPLAINT FORM

Person filling ou	t this form		
Date			
Last Name	First Name	Middle	Suffix
Address			
Telephone	Email		
Person(s) Discrimina	ted Against (if other than complain	ant)	
Name	Address		Telephone
Discriminatory I			
Government, organiz	zation, institution or business which	n you believe has discriminat	ted
Name			
Address			
When did the discrin	nination occur?		
Date			·
Describe the act(s) o	f discrimination providing the name	e(s) where possible of the inc	dividual(s) who discriminated:

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