

CITY OF SPARTA  
AMERICANS WITH DISABILITIES ACT (ADA) COORDINATOR  
6 LIBERTY SQUARE, SPARTA, TN 38583  
TEL: (931) 836-3248 FAX: (931) 836-3941  
spartagis@blomand.net

**GRIEVANCE FORM**

I. COMPLAINANT INFORMATION

Name of Complainant: \_\_\_\_\_  
Last First M

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

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

Telephone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Preferred Method(s) of Communication: (Check all that apply)

( ) Voice Telephone ( ) TTY ( ) E-mail ( ) US Mail & ( ) Other: \_\_\_\_\_

II. DESCRIBE YOUR COMPLAINT OF DISCRIMINATION BASED UPON DISABILITY.

Be specific and give date (s), time (s), and location (s). Use the reverse side of this sheet or attached pages, if needed.

III. PERSONS NAMED IN YOUR COMPLAINT. List the names of (or describe) all persons involved in your complaint. Indicate the job title and City Agency, department or division of City employees, if possible.

IV. WITNESS TO YOUR COMPLAINT. List the names of (or describe) all persons involved in your complaint. Indicate the job title and City Agency, department or division of City employees, if possible.

V. EVIDENCE AND DOCUMENTATION. List and provide any physical evidence, written or recorded documents, or any other information that directly supports your specific claim of discrimination.

VI. CASE REMEDY AND/OR RESOLUTION. What remedies or resolutions are you seeking?

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CERTIFICATION: I hereby certify that the information and statements above are true.

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

If person needing accommodation is not the individual completing this form, please provide

Representative's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
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For more information or assistance in completing this form, please contact the ADA Coordinator via (931) 836-3248 or [spartagis@blomand.net](mailto:spartagis@blomand.net)