CITY OF SPARTA
AMERICANS WITH DISABILITIES ACT (ADA) COORDINATOR
6 LIBERTY SQUARE, SPARTA, TN 38583
TEL: (931) 836-3248 FAX: (931) 836-3941
d.marcum@spartatn.gov

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?

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: __________________

For more information or assistance in completing this form, please contact the ADA Coordinator via (931) 836-3248 or d.marcum@spartatn.gov.