

ADA AND EEO COMPLAINT FORM

If an individual believes that they have received unequal treatment or discrimination while receiving services from Audrain Developmental Disability Services (ADDS) or employment. ADDS will make efforts to resolve complaints at the lowest level possible.

In order to file a complaint, please complete this form. If you require assistance with completing the form please contact our office at 573-581-8210.

Name _____

Address _____

Phone: Home _____ Work _____ Cell _____

Email address: _____

Basis of complaint (please circle all that apply):

- | | | | |
|------------|--------------------|-----------------------------|-----------------|
| Race | Color | Religion | National Origin |
| Sex/Gender | Sexual Orientation | Gender Identity | Age |
| Disability | Retaliation | Other, please specify _____ | |

Who discriminated against you?

Name _____

Name of Organization _____

Address _____

Phone _____

How were you discriminated against? (Attach additional pages if more space is required.)

Where did the discrimination occur?

Date and Time discrimination occurred?

Were there any other witnesses to the discrimination? If so, please list

Name _____
Organization _____
Phone _____ Home _____ Work _____

Name _____
Organization _____
Phone _____ Home _____ Work _____

How would you like to see situation resolved?

Please attach any written materials or other information that may be relevant to your complaint.

Signature _____ Date _____