



CITY OF WASHINGTON, ILLINOIS ADA GRIEVANCE FORM

Date: _____

Complainant Information:

Name: _____ Date of Occurrence: _____

Address: _____ Department of Occurrence: _____

City, State, Zip: _____ Address of Occurrence: _____

Phone: _____

Email: _____

Description of Grievance:

Please provide a detailed description of the grievance

Action Requested to Resolve Grievance:

Please state how you believe the grievance should be resolved:

Please attached additional pages as needed

Please return form to:
City of Washington
Attn: ADA Coordinator
301 Walnut
Washington, IL 61571

OR

E-Mail to:
dcarr@ci.washington.il.us

Upon request, reasonable accommodations will be provided in completing this form.
Please contact the ADA Coordinator at (309) 444-1136 or at the address listed above.

Office Use Only – Do Not Use

Received By: _____ Date Received: _____