



**The City Of Clayton
Grievance Form
Discrimination based on Disability**



It is the policy of the City of Clayton to provide assistance in filling out this form. If assistance is needed, please contact the ADA Coordinator at 314-290-8469.

NAME of Complainant: _____

NAME of Complainant's Representative (if one): _____

Complainant's ADDRESS: _____

CITY, STATE AND ZIP CODE: _____

TELEPHONE NO: Work: _____ Home: _____

Cell: _____ TDD: _____

TELEPHONE NO. of Representative: Home: _____ Alternate: _____

Best Means and Time for Contacting Complainant: _____

Best Means and Time for Contacting Representative: _____

Nature of Complainant's Physical or Mental Impairment: _____

What major life activities are substantially limited by the Impairment described above: _____

Program, Service, or Activity to which access was denied or in which alleged discrimination occurred: _____

Nature of alleged discrimination: _____

Date of alleged discrimination: _____ **Today's Date:** _____

Resolution requested: _____

I certify that I am qualified or otherwise eligible to participate in the program, service, or activity and the above statements are true to the best of my knowledge and belief.

Signature of Complainant: _____ **Date:** _____

I certify that I am qualified or otherwise eligible to participate in the program, service, or activity and the above statements are true to the best of my knowledge and belief.

Signature of Representative: _____ **Date:** _____