# AMERICANS WITH DISABILITIES ACT
## *COMPLAINT FORM*
## *ADA TITLE II*

The Board of Supervisors of the County of San Diego, is committed to eliminating discrimination on the basis of disability in providing public services, programs and activities and to making County facilities accessible. It is the policy of the County that services, programs and activities shall be in locations and facilities that are accessible to the extent required by the Americans with Disabilities Act, Title II.

### INSTRUCTIONS FOR COMPLETING COMPLAINT FORM:

Use the complaint form to identify any facility, service, program, activity, or personnel behavior, which you feel results in discrimination against people with disabilities. Please provide your name, address, and a telephone number where you can be reached. **Provide a concise statement of facts as to the basis of your complaint.** Include the location and date of the occurrence, or the location and date that you encountered a barrier. Include the names of any witnesses, who might be contacted for supporting information, during the investigation of your complaint. Please send or e-mail the completed form to the address below, or you may bring the completed form to any County Office. For special accommodation, contact the County ADA Coordinator at the number listed below.

### INSTRUCTIONS TO COUNTY STAFF AND VOLUNTEERS:

Please provide this form to anyone who requests information on how to record a complaint regarding accessibility or discrimination against people with disabilities. Do not attempt to determine whether the complainant has a legal standing or whether the complaint is valid. Forward completed complaint forms to the address below.

### FORWARD COMPLAINTS TO:

*County of San Diego*
*Office of Ethics and Compliance*
*1600 Pacific Highway Suite 400*
*San Diego, CA 92101*
*Todd.Hood@sdcounty.ca.gov*

*Attention: COUNTY ADA COORDINATOR, MS: A-6*

### INFORMATION:

Contact Todd Hood at (619) 531-4908, with any questions, or to request this information in alternative format.

# AMERICANS WITH DISABILITIES ACT
## *COMPLAINT FORM*
## *ADA TITLE II*

This complaint of discrimination on the basis of disability is filed by, or on behalf of, the following named disabled individual, against the County of San Diego:

LAST NAME | FIRST NAME | MIDDLE INITIAL

ADDRESS: STREET | CITY | STATE | ZIP

( ) DAYTIME TELEPHONE | ( ) OTHER TELEPHONE

DISABILITY (MEDICAL DIAGNOSIS OR DESCRIBE IN TERMS OF LIMITATION)

*Disability under the ADA is a physical or mental impairment that SUBSTANTIALLY limits one or more MAJOR life activities; a record of such an impairment; or being regarded as having such an impairment.*

The discrimination occurred *(time and date)* _____ at (location):

BUILDING NAME | COUNTY DEPARTMENT | ROOM

ADDRESS: STREET | CITY | STATE | ZIP

NAME(S) OF RESPONSIBLE COUNTY PERSONNEL OR WITNESS(ES)

**STATEMENT OF FACTS:** *Describe the incident or barrier, and any resulting discriminatory effect or loss of benefit. (You may attach additional paper.)*

**TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION AND STATEMENTS ARE TRUE AND ACCURATE:**

SIGNATURE OF COMPLAINANT OR AUTHORIZED REPRESENTATIVE | DATE

PRINT NAME OF COMPLAINANT OR AUTHORIZED REPRESENTATIVE | DATE

***Send completed form to:***

*By Mail: County of San Diego*
*Office of Ethics and Compliance*
*1600 Pacific Highway, Suite 400*
*San Diego, CA 92101*

*By Email:*
*oec@sdcounty.ca.gov*

*Attention: COUNTY ADA COORDINATOR, MS: A-6*