



AMERICANS WITH DISABILITIES ACT GRIEVANCE FORM

Name: _____ Home phone: _____

Address: _____ Cell phone: _____

_____ Business phone: _____

Date incident occurred: _____

Miami-Dade County department name and address where incident occurred:

Department name: _____

Incident address: _____

Please state the name, phone number and address of anyone with the related department you have contacted about your grievance as well as the date of the contact:

Name: _____ Phone number: _____

Address: _____ Contact date: _____

Describe grievance, including specific names, dates and locations. Attach more sheets if necessary.

Explain why you feel you have been discriminated against on the basis of your disability:

Signature of Complainant

Date Completed

Mail completed form or send via email to:

Office of ADA Coordination
111 NW 1st Street, 24th Floor
Miami, Florida 33128
adaoffice@miamidade.gov

To obtain this form in an alternative format, please call 305-375-3566 or send an email to adaoffice@miamidade.gov.