

**COMPLAINT FORM**

**CHARGING DISCRIMINATION AGAINST PEOPLE WITH DISABILITIES  
UNDER FEDERAL REVENUE SHARING REGULATIONS**

**(PLEASE TYPE OR PRINT CLEARLY)**

**Name:** \_\_\_\_\_

**Date Incident Occurred** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Dade County Department where incident occurred:**  
\_\_\_\_\_

**State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Address where incident occurred:**  
\_\_\_\_\_

**Home Telephone:** \_\_\_\_\_

**Have you contacted anyone in the above named department regarding your complaint?**

**Business Telephone:** \_\_\_\_\_

\_\_\_\_\_ **Yes** \_\_\_\_\_ **No**  
**If yes, name and telephone number of contact person:**  
\_\_\_\_\_

**Have you filed a formal complaint with the department?  
If yes, with whom? Name:** \_\_\_\_\_

\_\_\_\_\_ **Yes** \_\_\_\_\_ **No**  
**Telephone:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Describe nature of grievance. (Be specific – name, dates, location, etc.)  
(Attach additional sheet if necessary)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Explain why you feel you have been discriminated against on the basis of your disability:  
(Attach additional sheet if necessary)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Complainant**

\_\_\_\_\_  
**Date Completed**

**Mail Completed Form to: Office of ADA Coordination  
111 NW 1<sup>st</sup> Street, Suite 348  
Miami, Florida 33128**

**If you need assistance: call 305-375-3566**