Title II of the Americans with Disabilities Act  
Discrimination/ Grievance Complaint Form

Instructions: Please fill out this form completely if you feel you or someone that has  
authorized you to act on their behalf has been discriminated against based on disability.  
You may submit your completed form in person, or to the mailing address or email  
address below:

Cindy Lyle, ADA Coordinator  
404 West Palm Drive  
Florida City, Fl  33034  
305-242-8178  
com-dev@floridacityfl.gov

Complainant: ________________________________ ________________________________
Address: ________________________________________________________________
Contact Phone Number: ____________________ mobile:__________________________

Person discriminated against (if other than the complainant):  
Name: ________________________________________________________________
Address: ________________________________________________________________
Contact Phone Number: ____________________ mobile:__________________________

City of Florida Department which you believe has discriminated based on disability:
Department: ________________________________________________________________
Address: ________________________________________________________________
Has the Department received this complaint:  _____yes  _____no
If yes, what date: ________________________________
Have you filed a complaint with the Department of Justice or other agency?

[ ] yes  [ ] no

If yes, name of agency and contact information with which the complaint was filed:
_______________________________________________________________________
_______________________________________________________________________

When did the discrimination occur? Date of incident___________________________

Describe the acts of discrimination providing the name(s) where possible of the individual(s) who discriminated based on disability:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Remedy sought:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I confirm that 1) the information provided about the name of the person completing the form is correct, 2) The information provided in the description of the grievance section is, to the best of my knowledge, true and 3) if I completed this form on behalf of the person who was discriminated against, I am authorized to do so.

____________________________________   ____________ ______
Signature        Date