CENTRAL VIRGINIA ALLIANCE FOR COMMUNITY LIVING, INC.

P.O. Box 1390

Lynchburg, VA 24505

Title II of the Americans with Disabilities Act

Discrimination Complaint Form

Please fill out this for completely.
Print or type the information.
Sign and return this form to the address shown above.

Complainant Name:_____
Address:_____
City, State, Zip:_____
Home Phone:_____Cell Phone:_____
Email:_____
Person discriminated against (if other than complainant):_____
Address:_____
City, State,Zip:_____
Home Phone:_____Cell Phone:_____
Email:_____
Agency which you believe has committed a discriminating act:
Name:_____
Address:_____
City, State,Zip:_____
Phone:_____
Email:_____
When did the discrimination occur?
Date:_____Time:_____
Where did the discrimination occur?
Location:_____
Describe the acts of discrimination providing names (where possible) of individuals along with details of the incident.

_____
_____
_____
_____
_____
_____

_____
_____
_____
_____
_____

Has the complaint been filed with the Department of Justice or any other Federal, State or local civil rights agency or court?
Yes:_____No:_____

If yes, please provide the following information:
Agency or Court:_____
Contact Person:_____
Address:_____
City, State, Zip:_____