

Americans with Disabilities Act of 1990
Statement of Grievance

Name of Individual Making the Complaint _____

Address _____

City _____

State _____

Zip _____

Day Telephone _____

Evening Telephone _____

Complete the following section if the complaint is being filed by a person other than the individual making the complaint:

Complaint Filed By _____

Title (if appropriate) _____

Firm (if appropriate) _____

Address _____

City _____

State _____

Zip _____

Day Telephone _____

Evening Telephone _____

This section is for court use only:

Date Filed _____ Time Filed _____

Complaint Taken By _____

Staff Person's Name

Complainant's Last Name _____

1. Name the court or court facility in which the violation is alleged to have occurred

2. Describe what happened that led to the decision to file this complaint. (If necessary, use an additional page to complete the statement.)

Complainant's Last Name _____

3. State the desired remedy or the solution requested

4. List those witnesses who can provide information that supports or is relevant to your complaint

Witness _____

Address _____

City _____

State _____

Zip _____

Day Telephone _____

Evening Telephone _____

Witness _____

Address _____

City _____

State _____

Zip _____

Day Telephone _____

Evening Telephone _____

Please return completed Form by e-mail to crtinrp@coj.net, or call (904)255-1695 (or 711 Florida Relay Service) for alternate methods.