Title II of the Americans with Disabilities Act
Section 504 of the Rehabilitation Act of 1973
Discrimination Complaint Form

Instructions: Please fill out this form completely, in black ink or type. Sign and return to the address on page 3.

Complainant:_____

Address: _____

City, State and Zip Code: _____

Telephone:_____

Home: _____

Business: _____

Person Discriminated Against (if other than the complainant): _____

Address: _____

City, State, and Zip Code:_____

Telephone: Home:_____ Business:_____

Government, or organization, or institution which you believe has discriminated:

Name: _____

Address: _____

County: _____

City, State and Zip Code: _____

Telephone Number: _____

When did the discrimination occur? _____ Date: _____

Describe the acts of discrimination providing the name(s) where possible of the individuals who discriminated (use space on page 3 if necessary):

Have efforts been made to resolve this complaint through the internal grievance procedure of the government, organization, or institution?

Yes _____ No_____

If yes: what is the status of the grievance?

Has the complaint been filed with another bureau of the Department of Justice or any other Federal, State, or local civil rights agency or court?

Yes _____ No_____

If yes:

Agency or Court:_____

Contact Person: _____

Address: _____

City, State, and Zip Code:_____

Telephone Number: _____

Date Filed:_____

Do you intend to file with another agency or court?

Yes_____ No_____

Agency or Court:_____

Address: _____

City, State and Zip Code: _____

Telephone Number: _____

Additional space for answers:

Signature: _____

Date: _____

Return to: City of Owatonna

540 West Hills Circle

Owatonna, MN 55060