CITY OF ALBANY
TITLE II AMERICANS WITH DISABILITIES ACT
COMPLAINT FORM

INSTRUCTIONS: Please complete all parts of this form in black or blue ink or type. Sign, date, and return to the address on page 3.

PERSON DISCRIMINATED AGAINST:

NAME_____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE (H)_____ (W)_____

NATURE OF DISABILITY _____

Under the ADA, for an individual to be considered as having a disability, that individual must satisfy at least one of the following three conditions. They must either:

1. have a physical or mental impairment that substantially limits one or more of his or her major life activities; or
2. have a record of such impairment; or
3. be regarded as having such an impairment[1].

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[1] Under the ADA. See 42 U.S.C. § 12102. Under the "regarded as" prong, an individual must establish that he or she has been subjected to discrimination because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity. Id. Additionally, the impairment may not be transitory (actual or expected duration of 6 months or less) and minor. Id

INDIVIDUAL FILING COMPLAINT:

(COMPLETE ONLY IF THE COMPLAINT IS BEING FILED BY A PERSON OTHER THAN THE INDIVIDUAL DISCRIMINATED AGAINST)

NAME _____

TITLE_____

FIRM _____

ADDRESS _____

CITY _____ STATE_____ ZIP_____

TELEPHONE (H)_____ (W)_____

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ALLEGED DISCRIMINATION:

DATE OF DISCRIMINATION _____

LOCATION OF DISCRIMINATION_____

DESCRIBE THE ACTS OF DISCRIMINATION (use attachments if necessary)_____

_____

_____

_____

_____

_____

_____

STATE THE DESIRED REMEDY OR SOLUTION REQUESTED _____

_____

_____

_____

LIST THE NAMES AND TELEPHONE NUMBERS OF WITNESSES WHO CAN PROVIDE INFORMATION SUPPORTING YOUR COMPLAINT

WITNESS NAME WITNESS PHONE #

1. _____

2. _____

3. _____

HAS THIS ACT OF DISCRIMINATION BEEN REPORTED TO ANY OTHER STATE, LOCAL, OR FEDERAL
ENTITY?_____

DO YOU REQUIRE AUXILIARY AIDS OR SERVICES TO ENSURE EFFECTIVE COMMUNICATION DURING THE HEARING?

_____

IF YES PLEASE DESCRIBE. _____

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I HEREBY AFFIRM THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

SIGNATURE_____ DATE _____

PRINT NAME _____

RETURN TO:

Angelica Kang, Esq.
Chief Diversity Officer
ADA Coordinator
Department of Administrative Services
City Hall, Room 307
24 Eagle Street
Albany, New York 12207
akang@albanyny.gov