



**CITY OF ALBANY**  
**TITLE II AMERICAN 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. He or she 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<sup>1</sup>.

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\_\_\_\_\_  
<sup>1</sup> 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) \_\_\_\_\_

\*\*\*\*\*

**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. \_\_\_\_\_

\*\*\*\*\*

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

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

**RETURN TO:**

Adriana Le Blan, Esq.,  
*Assistant Corporation Counsel*  
*ADA Coordinator*  
Department of Law  
City Hall, Room 106  
24 Eagle Street  
Albany, New York 12207.  
For any questions call (518) 434-5050.