

# MOORHEAD

MINNESOTA

500 CENTER AVENUE, BOX 779, MOORHEAD, MINNESOTA 56561  
(218) 299-5301

## CITY OF MOORHEAD

### DISABILITY DISCRIMINATION COMPLAINT FORM

Instructions: Please fill out this form completely, in black ink or type. If you need any accommodation or assistance in completing this form, please contact the City of Moorhead ADA Coordinator at 299-5179. Sign and return to above address.

NAME OF COMPLAINANT \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

Department, Agency or Facility which you believe has discriminated:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_ County \_\_\_\_\_

Describe the acts of discrimination providing the name(s) of individuals who discriminated and location of discrimination:

When did discrimination occur? Date(s): \_\_\_\_\_

Describe any efforts made to resolve this complaint:

Action or relief requested by Complainant:

Has the complaint been file with another Bureau of the Department of Justice or other Federal, State or Local civil rights agency or court?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe:

Do you intend to file with another agency?

Yes \_\_\_\_\_ No \_\_\_\_\_

Agency or Court:

Address:

City, State and Zip Code:

Telephone Number:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Received by \_\_\_\_\_ Date \_\_\_\_\_  
(Human Resources Department)

**ACTION TAKEN:**

Signed: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_