

**TOWN OF WEST HARTFORD  
ADA COMPLAINT FOR PATRONS AND VISITORS**

Date of Incident: \_\_\_\_\_

**Person Completing Form (circle one):**

Complainant                      Authorized Representative

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

**Alleged Violation**

Describe the circumstances that prompted your specific ADA complaint. Please be specific and provide details. (Attach additional pages if necessary.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Requested Action**

Please describe the accommodation or request that would help to provide you with greater access to our facilities, programs or services.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Today's Date**

**Completed Forms should be returned to : Suzanne Oslander, ADA Coordinator  
Department of Social Services  
50 South Main Street, Room 130  
West Hartford, CT 06107  
Phone: 860-561-7580  
Email: [SuzanneO@WestHartfordCT.gov](mailto:SuzanneO@WestHartfordCT.gov)**