AMERICANS WITH DISABILITY ACT COMPLAINT FORM

Hoover City Schools

Name of Complainant _____ Position_____

Address _____

Phone_____ Email_____

Date of Alleged Discrimination _____

Location _____

Description of Problem:

_____

_____

_____

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_____ _____

Signature of Person Filing Complaint Date

_____ _____

Received By Date Received

Please submit this form to the Department of Human Resources prior to 30 days after the alleged violation.