



## **City of Covington Georgia Americans with Disabilities Act Discrimination Complaint Form**

Instructions: Please fill out this form completely, in black ink or type. Sign and return to the address on page 2.

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

Street Address: \_\_\_\_\_

City, State and ZIP Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Person Discriminated Against (if other than the complainant):

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

Street Address: \_\_\_\_\_

City, State and ZIP Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email Address: \_\_\_\_\_

City of Covington individual or department which you believe has discriminated:

Name/Department: \_\_\_\_\_

When did the discrimination occur? (Date / Time): \_\_\_\_\_

