Americans with Disabilities Act Complaint Form

The Cerebral Palsy League, Inc. is committed to ensuring that no person is denied access to its services, programs, or activities on the basis of their disabilities, as provided by title II of the Americans with Disabilities Act of 1990 ("ADA"). ADA complaints must be filed within 180 days from the date of the alleged incident.

The following information is necessary to assist us in processing your complaint. If you require any assistance in completing this form, or if you would like to make a verbal complaint, please contact:

Sharon Gribbin
The Cerebral Palsy League, Inc.
61 Myrtle St.
Cranford, NJ 07016
(908)-709-1800 ext.1128.

Complainant: _____

Phone:_____

Street Address:_____

City, State, Zip Code_____

Alt Phone:_____

Person Preparing Complaint (if different from Complainant): _____

Street Address, City, State, Zip Code _____

Date of Incident: _____

Please describe the alleged discriminatory incident, including the location(s), if applicable. Provide the names and titles of The Cerebral Palsy League, Inc. employees involved, if available.

_____
_____
_____
_____
_____

Description of incident continued:

_____
_____
_____
_____
_____

Have you filed a complaint with any other federal, state, or local agencies? Yes/No (Circle One).
If so, list agency/agencies and contact information below:

_____

Agency Contact Name:

_____

Street Address, City, State, Zip Code Phone:

_____

Agency Contact Name:

_____

I affirm that I have read the above charge and that it is true to the best of my knowledge, information, and belief.

_____ _____
Complainant's Signature Date

_____
Print or Type Name of Complainant

Date Received: _____

Received By: _____
Address: _____

City/State/Zip Code: _____

Telephone Number (Home): _____

Telephone Number (Work): _____