



Americans With Disabilities Act Complaint Form

Please use this form to file a complaint based on a disability in the provision of services, activities, programs or benefits. Please send this form to:

Human Resources Management
31st Floor, Corning Tower
Empire State Plaza
Albany, NY 12242
DEEO@ogs.ny.gov

Complainant Information

Name Email Phone

Address

State Agency

Your claim is made against:

Name Title Phone

Address

Complaint Circumstances

Complaint Location(s) Complaint Date(s)

Are the circumstances of your complaint continuing? Yes No

Please describe the alleged denial of services, activities, programs or benefits and your reason(s) for concluding that the conduct was discriminatory. Please include the name(s) of witnesses, if any, and attach supporting data, if available. Please attach additional pages if needed.

Have you filed a claim regarding this complaint with a federal, state or local government agency?	Yes	No
Have you hired an attorney with respect to the allegations in the complaint?	Yes	No
Have you instituted a legal suit or court regarding this complaint?	Yes	No
This complaint form was completed by:	DEEO	Complainant

Signature: _____ Date: _____