TITLE VI / ADA COMPLAINT FORM

Please provide the following information in order to process your complaint. Assistance is available upon request. Complete this form and mail or deliver to: Title VI /ADA Compliance Officer, Giles Health and Family Center, 701 Wenonah Ave., Pearisburg, Va. 24134. You can reach our office Monday-Friday from 8:00 am to 4:30 pm at 804.786.4440, or you can email us at director@gileshealthandfamily.org.

Person discriminated against (if other than complainant): Name:
Street Address: City: State: Zip Code:
Telephone No.:
The name and address of the agency, institution, or department you believe discriminated against you.
Name: Street Address:
City: State: Zip Code:
Date of incident resulting in discrimination:
Identify the category of Discrimination: Race _____ Color _____ National Origin _____ Disability _____

Describe how you were discriminated against.

What happened and who was responsible?

If additional space is required, please either use back of form or attach extra sheets to form.

Does this complaint involve a specific individual(s)? If yes, please provide the name(s) of the individual(s), if known.
Where did the incident take place?
Are there any witnesses?
If so, please provide their contact information: Name:
Street Address: City: State: Zip Code: Telephone No.:
Name: Street Address:
City: State: Zip Code: Telephone No.:
Did you file this complaint with another federal, state or local agency; or with a federal or state court?
θYes θNo If answer is Yes, check each agency complaint was filed with:
θFederal Agency θFederal Court θState Agency θState Court θLocal Agency θOther

Please provide contact person information for the agency you also filed the complaint with:
Name: Street Address:
City: State: Zip Code: Date Filed:
Sign the complaint in the space below. Attach any documents you believe support your complaint.
Complainant's Signature Signature Date