

# CITY OF SHELBYVILLE

INCORPORATED 1810  
AMERICANS WITH DISABILITIES ACT (ADA) COORDINATOR  
201 N. SPRING STREET  
SHELBYVILLE, TN 37160



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TEL: (931) 684-2691 FAX: (931) 684-1423  
[stacey.claxton@shelbyvilletn.org](mailto:stacey.claxton@shelbyvilletn.org)

## GRIEVANCE FORM

### I. COMPLAINANT INFORMATION

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

Last

MI

First

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Preferred Method(s) of Communication: (Check all that apply)

Voice Telephone  TTY  E-mail  US MAIL &  Other: \_\_\_\_\_

### II. DESCRIBE YOUR COMPLAINT OF DISCRIMINATION BASED UPON DISABILITY.

Be specific and give date(s), time(s) and location(s). Use the reverse side of this sheet or attached pages, if needed.

III. PERSONS NAMED IN YOUR COMPLAINT. List the names of (or describe) all persons involved in your complaint. Indicate the job title and City Agency, department or division of City employees, if possible.

**IV. WITNESSES TO YOUR COMPLAINT.** List the names of (or describe) all persons involved in your complaint. Indicate the job title and City Agency, department or division of City employees, if possible.

**V. EVIDENCE AND DOCUMENTATION.** List and provide any physical evidence, written or recorded documents, or any other information that directly supports your specific claim of discrimination.

**VI. CASE REMEDY AND/OR RESOLUTION.** What remedies or resolutions are you seeking?

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**CERTIFICATION: I hereby certify that the information and statements above are true.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If person needing accommodation is not the individual completing this form, please provide

Representative's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

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For more information or assistance in completing the form, please contact the  
ADA Coordinator via (direct line) (931) 684-2691 or  
[stacey.claxton@shelbyvilletn.org](mailto:stacey.claxton@shelbyvilletn.org)