CITY OF SOMERVILLE, MASSACHUSETTS

AMERICANS WITH DISABILITIES ACT DISCRIMINATION COMPLAINT FORM

JOSEPH A. CURTATONE
MAYOR

Complainant

Name: _____

Address: _____

City, State and Zip Code: _____

Contact Information

Telephone: Home: _____ Business: _____ Cell phone: _____

Email: _____

Person Alleged To Be Discriminated Against (if other than the complainant)

Discriminatory Incident

Government**,** organization, institution or business which you believe has discriminated.

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

Date discrimination occurred: _____

Primary type of disability: _____

Issue: _____

Describe the acts of discrimination: _____

165 Broadway • Somerville, Massachusetts 02145
(617) 625-6600, Ext. 2323 • Fax: (617) 625-3434
www.somervillema.gov

Have efforts been made to resolve this complaint through the internal grievance procedure of the government, organization, institution or business? Please describe those efforts.

Has the complaint been filed with any other Federal, State, or local civil rights agency or court? If yes, please indicate time and place of filing.

Signature: _____ Date: _____

Once the form is completed please send or bring to:

Nency Salamoun
City of Somerville
165 Broadway
Somerville, MA 02145
617-625-6600 x 2323
nsalamoun@somervillema.gov