CITY OF MOUNTAIN VIEW ADA GRIEVANCE FORM

In accordance with the requirements of the Americans with Disabilities Act (ADA) of 1990, the City of Mountain View will not discriminate against individuals on the basis of disability within the City's services, programs, facilities, or activities.

Completed Grievance Forms must be mailed or delivered to the City Manager's Office at 500 Castro Street, P.O. Box 7540, Mountain View, California, 94039-7540. If an accommodation is needed in order to submit the requested information, please call the City Manager's Office at 650-903-6301 to determine an appropriate alternative method for filing the complaint.

Full Legal Name:				
Address: Number/Street	Apt. No.	City	State	Zip
Home/Cell Phone:				
Business Phone:				
E-mail:				
Date of Incident:				
Time of Incident:				
Description of the alleged discri	iminatory service, pro	ogram, facility, o	or activity:	
Name(s) of involved City staff,	if any:			

Name(s), address(es), and telephone number(s) of witness(es), if any: Witness: _ Name Phone Address Witness: Name Phone Address **Desired Outcome:** I certify that the forgoing is true and correct. Submitted by: Printed Name: Signature: _____

Within fifteen (15) working days of the receipt of the ADA Grievance Form, the ADA Coordinator, or his/her designee, will respond in writing to the complainant with the decision rendered. The time frame for the ADA Coordinator's response may be extended for a reasonable period of time to ensure sufficient investigation, provided written notice of the extension is given to the complainant.

If the complaint cannot be resolved to the satisfaction of the complainant by the ADA Coordinator, it will be forwarded to a group of City staff consistent with City policy who will review and issue a written determination within an additional thirty (30) days. If a complaint cannot be resolved at this stage, the City Manager will make a final decision within an additional thirty (30) days.