



Citizen Accessibility Grievance Complaint Form

City of Corpus Christi - Human Resources Department,
ATTN: Sylvia Wilson, City Wide ADA Coordinator
1201 Leopard Street, Corpus Christi, TX 78401 Phone: (361)
826-3196



AGGRIEVED INDIVIDUAL / PERSON WITH DISABILITY

First Name: _____ Last Name: _____
Phone Number: (____) _____ E-Mail Address: _____
Address: _____ Apt. #: _____ City: _____ State: _____ Zip Code: _____

DESIGNEE OR PERSON AUTHORIZED TO FILE ON BEHALF OF THE AGGRIEVED INDIVIDUAL

First Name: _____ Last Name: _____
Phone Number: (____) _____ E-Mail Address: _____
Address: _____ Apt. #: _____ City: _____ State: _____ Zip Code: _____

BUSINESS OR ORGANIZATION BELIEVED TO HAVE DISCRIMINATED

Name of business, organization or institution which you believe has discriminated:

Address: _____ Suite #: _____ City: _____ State: _____ Zip Code: _____

If applicable, was the business entity informed of the issue? ☐ Yes ☐ No or ☐ Not Applicable

If Yes, provide the name or description of the person and date the issue was reported, if known.

First Name: _____ Last Name: _____ Month: _____ Day: _____ Year: _____

DATE OF INCIDENT Month: _____ Day: _____ Year: _____

DESCRIPTION OF ACCESSIBILITY COMPLAINT

Please describe the accessibility concern the person with the disability experienced. Provide location, date and description of the incident.

REQUESTED RESOLUTION OF GRIEVANCE

Please state what or how you feel the grievance may be resolved:

SIGNATURE: _____ **DATE:** _____