TOWNSHIP OF MIDDLETOWN

AMERICANS WITH DISABILITIES ACT COMPLAINT FORM

COMPLAINANT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	
ADDRESS	CITY	STATE	ZIP
PHONE NUMBER Home: ( ) -	Work (optional): ( ) -	DATE	

ALTERNATE CONTACT

LAST NAME	FIRST NAME	MIDDLE NAME	
ADDRESS	CITY	STATE	ZIP
PHONE NUMBER Home: ( ) -	Work (optional): ( ) -		

COMPLAINT INFORMATION

AGENCY ALLEGED TO HAVE DISCRIMINATED / DENIED ACCESS

DIVISION / UNIT

LOCATION (City / County)	DATE OF INCIDENT

INCIDENT OR BARRIER

Please describe in detail the alleged barrier or discriminatory conduct alleged to have occured.