



**City of Wausau**  
 AMERICANS WITH DISABILITIES ACT (ADA) TITLE II  
 DISCRIMINATION COMPLAINT FORM

**Instructions:** Please complete this form completely, sign and return to the address of the ADA Coordinator below.

Person Completing this Form:	<input type="checkbox"/> Citizen <input type="checkbox"/> Representative of Citizen
	Today's Date:
<b>Complainant Contact Information</b>	
Name:	
Street Address, Zip:	
Telephone Number:	
E-mail Address:	
Preferred Method of Contact:	<input type="checkbox"/> E-Mail <input type="checkbox"/> Telephone <input type="checkbox"/> Mail
<b>Representative of Citizen Contact Information</b>	
Name:	
Street Address, Zip:	
Telephone Number:	
Email Address:	
Preferred Method of Contact:	<input type="checkbox"/> E-Mail <input type="checkbox"/> Telephone <input type="checkbox"/> Mail

Date of alleged discrimination: \_\_\_\_\_

Describe the acts of discrimination providing the name(s) where possible the individuals who discriminated against you (attach additional pages as necessary).

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If you would like to include any additional information, please provide that information and attach it to this form.

\_\_\_\_\_  
 Signature of Citizen or Representative of Citizen

\_\_\_\_\_  
 Date

Return to:  
 Human Resources Department –ADA Coordinator  
 407 Grant Street  
 Wausau, WI 54403