

AMERICANS WITH DISABILITIES ACT AND REHABILITATION ACT COMPLAINT FORM

Please use this form to file a complaint based on disability in the provision of services, activities, programs or benefits.

Please submit this form to the ADA Coordinator, Cord Stone, Office of Employee Relations; you may find contact information for Cord Stone at the following: Office of Employee Relations, 2 Empire State Plaza, 12th Floor, Albany, New York 12223 or Cord.Stone@oer.ny.gov.

COMPLAINANT INFORMATION

Name:

Home Phone:

Home Address:

Email:

1. Your claim is made against:

State Agency:

Name:

Title:

Address:

Phone:

2. Location(s) and date(s) of the circumstances giving rise to your complaint:

Are the circumstances of your complaint continuing?

☐ Yes ☐ No

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- This image shows a full page of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page, providing a template for handwriting practice or general writing. There are no margins, text, or other markings on the page.

- ☐ Yes ☐ No

- ☐ Yes ☐ No

- ☐ Yes ☐ No

- ☐ ADA Coordinator ☐ Complainant

SIGNATURE: _____

DATE: _____