

Department of Public Health & Human Services
Americans with Disabilities Act
Complaint Resolution Form

Name: _____

Mailing Address: _____

Telephone Number: _____ (8:00a.m.to 5:00 p.m. Monday-Friday)

Please explain what discriminatory action was taken against you. Be specific. Include dates, names, places, actions/events, witnesses, etc. (attach additional sheets if necessary): _____

_____ [] Additional page(s)

Specific corrective action you are seeking: _____

_____ [] Additional page(s)

Signature

Date

Alternative accessible formats of this document are available upon request. For further information, or to submit a complaint, contact: DPHHS Human Resources, ADA Coordinator, P.O. Box 4210, Helena, MT 59604, (406) 444-3136.