SOLANO COUNTY
AMERICANS with DISABILITIES ACT (ADA)
PUBLIC ACCESS
COMPLAINT FORM

Instructions: Please fill out this form completely, in black ink or type. Sign and return to the Department of Human Resources, 675 Texas Street, 1st Floor, Suite 1800, Fairfield, CA 94533.

Complainant: _____

Address: _____

City, State & Zip Code _____

Home Phone:_____

Business Phone: _____

Person Discriminated Against: (if other than the complainant)

Name: _____

Address: _____

City, State & Zip_____

Home Phone:_____

Business Phone: _____

Government, organization, or institution that you are bringing forth the complaint against:

Name: _____

Address: _____

City, State & Zip_____

County: _____

Business Phone: _____

Public Access Complaint:

Date of Incident: _____

Please describe the details of your complaint (use additional pages if necessary):

_____

_____

_____

_____

Have efforts been made to resolve this complaint through the internal grievance procedure of the government, organization, or institution? Yes ☐ No ☐

If Yes, what is the status of the grievance?_____

_____

_____

_____

_____

Has the complaint been filed with the Department of Justice or any other Federal, State, or local civil rights agency or court? Yes ☐ No ☐

If yes:

Agency or Court:_____

Contact Person: _____

Address: _____

City, State & Zip Code: _____

County: _____

Phone Number: _____

Date Filed:_____

Do you intend to file with another agency or court? Yes ☐ No ☐

Agency or Court:_____

Address: _____

City, State & Zip Code _____

County: _____

Phone Number: _____

Signature _____ Date _____