Citizen Accessibility Grievance Form

City of Corpus Christi - Human Relations Division
1201 Leopard Street, 1st Floor, Corpus Christi, TX 78401
Phone: (361) 826-3190 Fax: (361) 826-3192

AGGRIEVED INDIVIDUAL / PERSON WITH DISABILITY

First Name: _____ Last Name: _____

Phone Number: (____) _____ E-Mail Address: _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip Code: _____

DESIGNEE OR PERSON AUTHORIZED TO FILE ON BEHALF OF THE AGGRIEVED INDIVIDUAL

First Name: _____ Last Name: _____

Phone Number: (____) _____ E-Mail Address: _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip Code: _____

BUSINESS OR ORGANIZATION BELIEVED TO HAVE DISCRIMINATED

Name of business, organization or institution which you believe has discriminated:

_____

Address: _____Suite #: _____ City: _____ State: ____ Zip Code: _____

DATE OF INCIDENT

Month: _____ Day: _____ Year: _____

DESCRIPTION OF ACCESSIBILITY COMPLAINT

What discriminatory harm did the person with the disability experience? Please describe the accessibility complaint. Indicate information about the alleged discrimination, including but not limited to location(s) of problem(s), date of problem(s) and description of the problem(s):

_____

_____

_____

Was the business entity informed of the issue? ☐ Yes ☐ No
If Yes, provide the name of the person and date the issue was reported, if known.

First Name: _____ Last Name: _____ Month: _____ Day: _____ Year: _____

REQUESTED RESOLUTION OF GRIEVANCE

Please state what or how you feel the grievance may be resolved:

_____

_____

_____

SIGNATURE: _____ **DATE:** _____