

**CITY OF SAN CLEMENTE**

**AMERICANS WITH DISABILITIES ACT (ADA)  
GRIEVANCE FORM  
INSTRUCTIONS**

*This is a printable form. Simply complete, print, and send to: City of San Clemente,  
Attn: ADA Coordinator, 100 Avenida Presidio, San Clemente, CA 92672  
Or Fax to 949-361-8300*

**COMPLAINANT INFORMATION**

**NAME**

**ADDRESS**

**CITY**

**STATE**

**ZIP CODE**

**HOME PHONE (include area code)**

**BUSINESS PHONE (include area code)**

**PERSON ALLEGING ADA VIOLATION (if other than complainant)**

**NAME**

**ADDRESS**

**CITY**

**STATE**

**ZIP CODE**

**HOME PHONE (include area code)**

**BUSINESS PHONE (include area code)**

**INFORMATION ON ALLEGED VIOLATION**

**DATE ALLEGED VIOLATION OCCURRED**

**DESCRIPTION OF ALLEGED VIOLATION**

**REQUESTED REMEDY**

**OTHER COMMENTS**

**SIGNATURE**

**DATE**

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