Medina County ADA Complaint Form

This form is to be completed by an employee protected by the Americans with Disabilities Act (ADA) having a complaint about the Boards' compliance with providing a suitable accommodation to perform the essential functions of their job. Please submit this form and any supporting documentation to the Director of Human Resources.

Name: _____ **Dept**. _____

Dept. Phone: (____) _____- _____ **Home Phone**: (____) _____- _____

Email: _____ **Job Title:** _____

Address: _____ _____
Street No. or Post Box Apt. or Unit No.

_____ _____
City Zip

Barrier(s) to performing essential functions of position:

_____

_____

_____

_____

Prior accommodation(s) provided:

_____

_____

_____

_____

Describe any contact(s) you have previously had about this issue:

_____

_____

_____

_____

Description of requested accommodation(s):

_____

_____

_____

_____

_____ _____
Employee Name – Print Date

_____ _____
Employee Name – Signature Date

To be completed by Human Resources:

Received by: _____ Dated Received: _____

Dept. of Employee Contacted (Date): _____

Name of Dept. Contact: _____

Response to Complainant sent (Date):_____
(Attach copy of response to this form)