

New York State Canal Corporation
 123 Main Street
 White Plains, NY 10601
 Phone No.: (914) 681-6246
 E-mail: accommodations@nypa.gov

Clear Form

AMERICANS WITH DISABILITIES ACT COMPLAINT

Purpose: This form is used to file a complaint based on disabilities in the provision of services, activities, programs or benefits.

INSTRUCTIONS: Please submit this form to the Affirmative Action Officer at the mailing or e-mail address above.

Section I Complainant Information			
Name (Last, First, MI)		Home Phone No. () -	E-mail Address
Mailing Address	City	State	Zip Code -

Section II Details of Claim

<input type="checkbox"/>	<input type="checkbox"/>
Location(s) and date(s) of the circumstances giving rise to your complaint?	
Are the circumstances of your complaint continuing? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please describe the alleged denial of services, activities, programs or benefits and your reason(s) for concluding that the conduct was discriminatory. Please include the name(s) of witnesses, if any, and attach supporting documentation, if available.

Have you filed a claim regarding this complaint with a federal, state or local government agency? Yes No

Have you hired an attorney with respect to the allegations in the complaint? Yes No

Have you instituted a legal suit or court action regarding this complaint? Yes No

This complaint form was completed by: Director of CRI Complainant

Signature

Date