CITY OF BUFFALO

TITLE II AMERICANS WITH DISABILITIES ACT

DISABILITY DISCRIMINATION

APPEAL FORM

Instructions: Please complete all parts of this form in black or blue ink or type. Sign, date, and return to the address on page 3.

PERSON DISCRIMINATED AGAINST:

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE (H)_____ (W)_____

****

INDIVIDUAL FILING APPEAL:

(COMPLETE ONLY IF THE APPEAL IS BEING FILED BY A PERSON OTHER THAN THE INDIVIDUAL DISCRIMINATED AGAINST)

NAME _____

TITLE_____

FIRM _____

ADDRESS _____

CITY _____

STATE_____ ZIP_____

TELEPHONE (H)_____ (W)_____

****

APPEAL:

LOCATION WHERE DISCRIMINATION OCCURRED _____

DATE ORIGINAL COMPLAINT FILED _____

DATE OF HEARING _____

DATE OF DECISION _____

LIST THE NAMES AND TELEPHONE NUMBERS OF WITNESSES WHO CAN PROVIDE INFORMATION SUPPORTING YOUR COMPLAINT

witness name witness phone #

1. _____

2. _____

3. _____

IN YOUR OWN WORDS BRIEFLY EXPLAIN THE WRITTEN DECISION REGARDING THE ORIGINAL COMPLAINT_____

_____

_____

WHY ARE YOU APPEALING THE DECISION?_____

_____

_____

STATE THE DESIRED REMEDY OR SOLUTION REQUESTED _____

_____

_____

DO YOU REQUIRE AUXILIARY AIDS OR SERVICES TO ENSURE EFFECTIVE COMMUNICATION DURING THE HEARING? _____

IF YES, PLEASE DESCRIBE _____

I HEREBY AFFIRM THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

SIGNATURE_____ DATE _____

PRINT NAME _____

RETURN TO:

DAVID RODRIGUEZ
ACTING CORPORATION COUNSEL
CITY OF BUFFALO LAW DEPARTMENT
65 NIAGARA SQUARE
1101 CITY HALL
BUFFALO, NEW YORK 14202