



Town of Fairplay Complaint/Grievance Form
Title II of the Americans with Disabilities Act

Name of Grievant: _____

Person Preparing Complaint (if different from Grievant): _____

Relationship of Preparer to Grievant (if applicable): _____

Address of Grievant: _____

City: _____ State: _____ Zip: _____

Phone Number of Grievant: _____ Email: _____

Nature of Grievance:

Please provide a complete description of the specific complaint or grievance, including any incident, barrier, or perceived denial of benefit of any service, program, or activity:

Please specify any location(s) related to the complaint or grievance (if applicable):

Please state what you think should be done to resolve the complaint or grievance:

Please attach additional pages as needed

Signature _____ Date: _____

Please return this form in hard copy or email to:

Kim Wittbrodt
ADA Coordinator
PO Box 267
Fairplay, CO 80440
kwittbrodt@fairplayco.us
(719) 836-2622 ext. 103

