AMERICANS WITH DISABILITIES ACT (TITLE II) COMPLAINT FORM

The City of Norman ensures that no person or groups of persons shall, on the grounds of race, color, sex, religion, national origin, age, disability, retaliation or genetic information, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any and all programs, services, or activities administered, its recipients, subrecipients, and contractors. To request an accommodation and/or an alternate format, please contact Shawn O'Leary, ADA/504 Coordinator at 405-366-5453, or Oklahoma Relay by dialing 7-1-1 or 1-800-522-8506.

R M	Date of Filing:		_
= JML =	Name:		_
	Address:		_
	City, State, Zip Code:		_
ANK ?	Work Phone:		_
AV /	Home Phone:		_
	Email Address:		
くなく	Date of Alleged Incident:		- -
Indicate below the pers	son(s) who you believe discrim	inated against you:	
Name(s):			
Work Location:			
Work Phone:			
		ncidence of discrimination. If there are an Attach additional pages as necessary.	ıy
			-
Please provide a sugge necessary.	ested detailed plan or remedy t	for this complaint. Attach additional page	s as

Have you filed or do you int (Federal, State or Local)?	end to file a complaint concerning this incident with any other agencies
☐ Yes ☐ No	
If so, please provide the following	lowing information:
Agency Name:	
Address:	
Name of Investigator:	
Phone Number:	
Email Address:	
Date Filed:	
•	
Status of Complaint:	
Please attach and/or prov processing your complain	ride any additional information that might be useful in nt.
The completed form must b	e submitted to:
	Shawn O'Leary, ADA/504 Coordinator 201 West Gray, Bldg. A Norman, OK. 73069 Phone: 405-366-5453 shawn.oleary@normanok.gov
Signature	