

SAN DIEGO UNIFIED PORT DISTRICT  
**COMPLAINT RESOLUTION FORM FOR ALLEGED DISCRIMINATION  
 ON THE BASIS OF DISABILITY**

Department:		
Complaint Received By:		Phone #:
Department Action Taken:		
Referred for Resolution To:		Date:
Final Resolution:		
		Date:
Complainant Notified By:	<input type="checkbox"/> Phone	<input type="checkbox"/> Letter
	<input type="checkbox"/> Person	
Date:	By Whom:	
ADA Liaison Signature:		
Phone #:	Fax #:	Date:
Notes:		
Assignment #:		