

SAN DIEGO UNIFIED PORT DISTRICT

ADA GRIEVANCE REPORT

This form is to be completed by a complainant under the Americans with Disabilities Act, as outlined in the District's Administrative Procedure #261, dated \_\_\_\_\_.

FOR DISTRICT USE ONLY

DATE RECEIVED:

- 1. by District Clerk \_\_\_\_\_
- 2. by Supervisor \_\_\_\_\_
- 3. by Department Head \_\_\_\_\_

- 4. by Human Resources \_\_\_\_\_
- 5. by Port Director \_\_\_\_\_
- Date Final Decision Recorded \_\_\_\_\_

Complainant's Full Name

Complainant's Mailing Address

Complainant's Daytime Phone #

Date of Report

IF EMPLOYEE, PLEASE INDICATE:

Classification

Department

PART I (ATTACH ADDITIONAL SHEETS IF NECESSARY)

1. Describe the incident or activity that has occurred which has caused you to be grieved. Include who, what, where, when, how and why:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Describe how the District created the alleged situation described above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. What loss or damage have you suffered as a result of the activity or incident described in #1:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. What remedy do you seek from this incident which you believe is within the authority of the District to remedy:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date Completed

Complainant's Signature