TA-W1003-9 (12/2014)

Clear Form

New York State Canal Corporation 123 Main Street White Plains, NY 10601 Phone No.: (914) 681-6246

Phone No.: (914) 681-6246 E-mail: accessibility@nypa.gov

AMERICANS WITH DISABILITIES ACT COMPLAINT

Purpose: This form is used to file a complaint based on disabilities in the provision of services, activities, programs or benefits.

INSTRUCTIONS: Please submit this form to the Director, Civil Rights & Inclusion (CRI) at the mailing or e-mail address above.

Section I Complainant Information					
Name (Last, First, MI)		Home Phone No.		E-mail Address	
		() -	-		
Mailing Address	City	,	S	State	Zip Code
					-
Section II Details of Claim					
Location(s) and date(s) of the circumstances giving rise to your complaint?					
Are the circumstances of your complaint continuing?	Yes	No			
Please describe the alleged denial of services, activities, programs or benefits and your reason(s) for concluding that the conduct was					
discriminatory. Please include the name(s) of witnesses, if any, and attach supporting documentation, if available.					
Have you filed a claim regarding this complaint with a federal, state or local government agency?					
Have you hired an attorney with respect to the allegations in the complaint?					
Have you instituted a legal suit or court action regarding	this complain	t? Yes	☐ No		
This complaint form was completed by: Director of	CRI C	omplainant			
_	_				
Signature				Da	ate