

**Americans with Disabilities Act
Section 504 of the Rehabilitation Act of 1973
Grievance Form**

Instructions: Please fill out this form completely. A printed or typed response is recommended. Sign and return to the address on last page by email, fax, mail or in person. If you need an accommodation to complete or submit this form, please contact the ADA Coordinator as indicated on this form.

1. Complainant: _____

Address: _____

City, State and Zip Code: _____

Telephone: Home: _____ Business: _____

2. Person Discriminated Against: (if other than the complainant): _____

Address: _____

City, State, and Zip Code: _____

Telephone: Home: _____ Business: _____

3. Department or person which you believe has discriminated (if known):

Name: _____

Address: _____

City, State and Zip Code: _____

Telephone Number: _____

When did the discrimination occur? Date: _____

4. Describe the acts of discrimination providing the name(s) where possible of the individuals who discriminated:

5. Have efforts been made to resolve this complaint?

Yes_____ No_____

If yes: what efforts have been taken and what is the status of the grievance?

6. Additional comments or information:

Signature: _____ Date: _____

Return to:

**Marjorie De La Cruz
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Email: ADA@pstramway.com
Phone: 760-325-1449 ext. 127 FAX: 760-325-2621
TTY by California Relay at: 711**