New York State
Department of Labor
Division of Equal Opportunity Development

AMERICANS WITH DISABILITIES ACT
COMPLAINT FORM

Please use this form to file a complaint based on disability in the provision of services, activities, programs or benefits.

Please submit this form to the ADA Coordinator, NYS Department of Labor's (DOL) Designee for Reasonable Accommodation (DRA) (Director of the Division of Equal Opportunity Development [DEOD]); you may find contact information for the ADA Coordinator/DRA (Director of DEOD) at www.labor.ny.gov.

COMPLAINANT INFORMATION

Name: Home Phone:

Home Address: Email:

1. Your claim is made against:

   State Agency:

   Name:

   Title:

   Address:

   Phone:

2. Location(s) and date(s) of the circumstances giving rise to your complaint:

   Are the circumstances of your complaint continuing?
   ☐ Yes ☐ No

3. 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 data, if available.

4. A. Have you filed a claim regarding this complaint with a federal, state or local government agency?
☐ Yes ☐ No

   B. Have you hired an attorney with respect to the allegations in the complaint?
☐ Yes ☐ No

   C. Have you instituted a legal suit or court action regarding this complaint?
☐ Yes ☐ No

5. This complaint form was completed by:
☐ ADA Coordinator ☐ Complainant

SIGNATURE: _____ DATE: _____