OFFICE OF THE STATE COURT ADMINISTRATOR
AMERICANS WITH DISABILITIES ACT
GRIEVANCE FORM

Complainant Name:		**Date:**
Address:		
City:	**State:**	**Zip Code:**
Home Phone:	**Alternate Phone:**	
Department - City and State Location:		

Description of the alleged violation *(please be specific and include all necessary information such as accommodation denied, date and time of incident, name and phone number of any Colorado Judicial Department employee you interacted with, name and phone number of any witnesses, etc.)*

I require alternative means of filing my complaint. Please contact me at one of the phone numbers below to make arrangements.

Phone Number:	**Alternate Number:**

Mail this form to:

Director of Human Resources
1300 Broadway, Suite 1200
Denver, CO 80203
720-625-5000

Form should be received no later than 60 calendar days after the alleged violation.