Please provide the following information in order to process your complaint. Assistance is available upon request. Complete this form and mail or deliver to:

You can reach the ADA Compliance Coordinator Monday – Friday from 8:00 4:30 pm at 804-225-4185, or email lisa.cates@dvs.virgnia.gov. VDVS, 101 N. 14th Street, 17th Floor, Richmond, VA 23219

Complainant’s Name: _____________________________________________________________

Street Address: _______________________________________________________________________________________

City: __________________________ State: __________________ Zip Code: _________________________

Telephone No. (Home): __________________________ (Business): __________________________

Person discriminated against (if other than complaint):

Name: _______________________________________________________________________________________

Street Address: _______________________________________________________________________________________

City: __________________________ State: __________________ Zip Code: _________________________

Telephone No. (Home): __________________________ (Business): __________________________

The name and address of the agency, institution, or department you believe discriminated against you:

Name: _______________________________________________________________________________________

Street Address: _______________________________________________________________________________________

City: __________________________ State: __________________ Zip Code: _________________________

Date of incident resulting in discrimination: __________________________

Identify the category of discrimination:

Race ________ Color ________ National Origin ________ Disability ________
Describe how you were discriminated against. What happened and who was responsible? If additional space is required, please use back of form or attach extra sheets to form.

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Does this complaint involve a specific individual(s) associated with VDVS? If yes, please provide the name(s) of the individual(s) if known.

__________________________________________________________________________________________

__________________________________________________________________________________________

Where did the incident take place?

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Are there any witnesses? If so, please provide their contact information:

Name: __________________________________________________________
Street Address: _________________________________________________
City: _________________________ State: __________________________ Zip Code: _________________________
Telephone No.: ______________________________

Did you file this complaint with another federal, state or local agency; or with a federal or state court?

☐ Yes  ☐ No

If answer is yes, check each agency complaint was filed with:

☐ Federal Agency ☐ Federal Court ☐ State Agency
☐ State Court ☐ Local Agency ☐ Other

Please provide contact person information for the agency you also filed the complaint with:

Name: __________________________________________________________
Street Address: _________________________________________________
City: _________________________ State: __________________________ Zip Code: _________________________
Telephone No.: ______________________________ Date Filed: ______________________________

Sign the complaint in the space below. Attach any documents you believe support your complaint.

_________________________________  __________________________
Complaint’s Signature  Signature Date