



Americans with Disabilities Grievance 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 accessibility@spo.nm.gov or by mail to:

ADA Coordinator
State Personnel Office
2600 Cerrillos Rd
Santa Fe, NM 87505-3258

Complainant Information

Last Name

First Name

Title

Phone

Address

1. Your Claim is made against:

State Agency

Phone

Address

Name of state employee (if applicable)

Title

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

Are these circumstances continuing?

Yes

No



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3. Please describe the alleged denial of services, activities, programs or benefit and your reason(s) for concluding that the conduct was discriminatory. Please include the names(s) of witnesses, if any, and attach supporting information, if available.

4. Have you filed a claim regarding this complaint with a federal, state, or local government agency?

Yes No

5. Have you hired an attorney with respect to the allegations in the complaint?

Yes No

6. Have you instituted a legal suit or court action regarding this complaint?

Yes No

7. This form was completed by:

Complainant

Assistance to the Complainant

ADA Coordinator

Name of person completing this form

Signature

Date