



# New Jersey Judiciary

## AMERICANS WITH DISABILITIES ACT COMPLAINT FORM



### COMPLAINANT INFORMATION

LAST NAME		FIRST NAME		MIDDLE NAME	
ADDRESS			CITY	STATE	ZIP
PHONE NUMBER	Home: ( ) -	Work (optional): ( ) -	DATE		

### ALTERNATE CONTACT

LAST NAME		FIRST NAME		MIDDLE NAME	
ADDRESS			CITY	STATE	ZIP
PHONE NUMBER	Home: ( ) -	Work (optional): ( ) -			

### COMPLAINT INFORMATION

AGENCY ALLEGED TO HAVE DISCRIMINATED / DENIED ACCESS	<input type="checkbox"/> Supreme Court	<input type="checkbox"/> Appellate Division	<input type="checkbox"/> Tax Court	<input type="checkbox"/> Municipal Court
	<input type="checkbox"/> Superior Court	<input type="checkbox"/> Other _____		
COURT / DIVISION / UNIT				
LOCATION (City / County)			DATE OF INCIDENT	
INCIDENT OR BARRIER				

PLEASE DESCRIBE THE PARTICULAR WAY IN WHICH YOU BELIEVE YOU HAVE BEEN DENIED ANY SERVICE, PROGRAM, OR ACTIVITY OF THE JUDICIARY, OR HAVE OTHERWISE BEEN DISCRIMINATED AGAINST BECAUSE OF, OR RELATED TO, A DISABILITY. PLEASE SPECIFY DATES, TIMES OF INCIDENTS, AND NAMES OR POSITIONS OF JUDICIARY EMPLOYEES INVOLVED. PLEASE PROVIDE NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ANY WITNESSES. PLEASE ATTACH ADDITIONAL PAGES IF NECESSARY.

---

---

---

---

---

---

---

---

---

---

IF YOU NEED HELP IN COMPLETING THIS FORM CONTACT THE LOCAL JUDICIARY ADA COORDINATOR. PLEASE RETURN THIS FORM TO THE LOCAL ADA COORINATOR OR TO: