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

☐ Supreme Court ☐ Appellate Division ☐ Tax Court ☐ Municipal Court

☐ Superior Court ☐ 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: