ADA DISCRIMINATION COMPLAINT FORM

The San Bernardino County Transportation Authority (SBCTA) is committed to ensuring that no person is excluded from participating in or denied the benefits of its services on the basis of disability as provided by the American with Disabilities Act (ADA) of 1990 as well as other applicable law. Complaints must be filed within 180 days from the date of the alleged discrimination. The following information is necessary to assist SBCTA in processing your complaint. If you require any assistance in completing this form, please contact the ADA Coordinator, Colleen Franco, by calling (909) 884-8276.

When completed, submit the original signed form or letter in person, email or by mail to:

Colleen Franco
Director of Management Services
San Bernardino County Transportation Authority
1170 W 3rd St., 2nd Floor
San Bernardino, CA 92410
adacoordinator@gosbcta.com

FOR QUESTIONS OR ASSISTANCE IN OTHER ACCESSIBLE FORMATS SUCH AS LARGE PRINT, TDD, AUDIO, OR OTHER PLEASE CALL: (909) 884-8276.

USERS WITH HEARING OR SPEECH IMPAIRMENTS, USE THE CALIFORNIA RELAY SERVICE, 711, AND THEN THE NUMBER YOU NEED.

1. **Contact Information:**
   Complainant's Name: _____
   Address: _____
   City, State and Zip Code: _____
   Telephone: _____(home/work)_____(cell)

What are the most convenient days and times for SBCTA to contact you about this complaint?
_____

2. Are you filing this complaint on your own behalf? Yes: ☐ No: ☐

   If you answered yes, please go to question #3.

   If you answered no, Please provide your contact information

   Name: _____
   Address: _____
   City, State and Zip Code: _____
   Telephone: _____(home/work)_____(cell)

   Please explain why you have filed for a third party:

   _____

   _____

   If you answered no, please confirm that you have obtained the permission of the aggrieved party if you are filing on behalf of a third party. Yes: ☐ No: ☐

3. Date and place of alleged discriminatory action(s):

Include the earliest date of discrimination and the most recent date of discrimination:

Date:_____ Location: _____
Date:_____ Location: _____

4. How were you discriminated against?

Describe the nature of the action, decision, or conditions of the alleged discrimination. Explain as clearly as possible what happened and why you believe your protected status was a factor in the discrimination. Include how other persons were treated differently from you. (Attach additional page(s) ifnecessary).

5. **Names of individuals responsible for the discriminatory action(s):**

6. **Names of individuals (witnesses, fellow employees, supervisors, or others) whom we may contact for additional information to support or clarify your complaint(s):**

Name	Address	Telephone No.

7. **What remedy or action are you seeking for the alleged discrimination?**

8. **Has this complaint been filed with any other Federal, State, or local investigative agency?**
   No □ Yes □ If "yes," please provide the following information:
   Agency:
   Contact Person: _____
   Address: _____
   Telephone No.: _____
   Date Filed: _____

9. **Please provide any additional information that you believe would assist in the investigation:**

Please sign and date this form:

_____ _____

Signature of Complainant **Date**

This form is available in alternative formats.