For use in any Court of the State of Illinois
Grievance Form under the Americans with Disabilities Act

(REQUEST TO REMAIN CONFIDENTIAL)

Date: _____

Please Print:

Name of person submitting grievance:_____

Address:_____

Daytime phone number: _____E-mail: _____

_____

Original date of denied request:
_____

Reason (s) for grievance:
_____
_____
_____
_____

_____

Please state your suggested outcome for resolution:
_____
_____
_____
_____
_____

Signature of Requesting Party _____

Please send a copy of the completed form by email to the Court Disability Coordinator for your courthouse. (insert link here).

For Office Use:

Print Completed Form **Save Completed Form**