

The Moccasin Express

Americans with Disabilities Act Discrimination Complaint Form

Please complete this form.

Last Name _____ First Name _____

Address _____

City _____ State _____ ZIP _____

Telephone _____ Email _____

Person(s) Discriminated Against (if other than the complainant)

Discriminatory incident

When did the discrimination occur? Date

Primary type of disability

Describe the acts of discrimination

Witnesses to this incident

Your complaint will be taken seriously and addressed immediately by The Moccasin Express Administration. A response will be provided to you by mail.

If you have any questions or concerns please call The Moccasin Express at 509-458-6549 or 509-458-6564