



## ADA DISCRIMINATION COMPLAINT FORM

The Riverside County Transportation Commission (RCTC) is committed to ensuring that no person is excluded from participating in or denied the benefits of its services on the basis of race, color, or national origin as provided by Title VI of the Civil Rights Act of 1964, as amended. Complaints must be filed within 180 days from the date of the alleged discrimination. The following information is necessary to assist RCTC in processing your complaint. If you require any assistance in completing this form, please contact the American with Disabilities (ADA) coordinator, Aaron Hake, by calling (951) 787-7141.

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

Aaron Hake, Deputy Executive Director  
Riverside County Transportation Commission  
4080 Lemon Street, Third Floor  
P. O. Box 12008  
Riverside, CA 92502-2208

**FOR QUESTIONS OR ASSISTANCE IN OTHER ACCESSIBLE FORMATS SUCH AS LARGE PRINT, TDD, AUDIO, OR OTHER PLEASE CALL: (951) 787-7141.**  
**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 RCTC 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 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. Basis of discriminatory action(s):**

Check (  ) all categories below that apply to the act(s) of discrimination.

a.	<input type="checkbox"/>	Race				
b.	<input type="checkbox"/>	Color				
c.	<input type="checkbox"/>	Gender (please indicate gender)	<input type="checkbox"/>	Male	<input type="checkbox"/>	Female
d.	<input type="checkbox"/>	Sexual Harassment				
e.	<input type="checkbox"/>	Retaliation				
f.	<input type="checkbox"/>	Disability (specify the name of your disability and/or provide a brief description of its symptoms)				
g.	<input type="checkbox"/>	Age (please indicate your age)				
h.	<input type="checkbox"/>	Income status				
i.	<input type="checkbox"/>	Other (please explain)				

**4. 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: \_\_\_\_\_

**5. 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) if necessary).

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

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

<u>Name</u>	<u>Address</u>	<u>Telephone No.</u>
_____	_____	_____
_____	_____	_____

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

**9. 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: \_\_\_\_\_

**10. 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.