ILLINOIS SEVENTEENTH JUDICIAL CIRCUIT COURT
COUNTIES OF WINNEBAGO AND BOONE

Grievance Form

For Complaints related to Title II of the Americans with Disabilities Act.

Date: _____

1) Person alleging grievance:

Name: _____

Address: _____

E-mail: _____ Telephone/TTY Number: _____

Select one of the following options:
[ ] Defendant [ ] Litigant/Party [ ] Witness [ ] Victim [ ] Juror [ ] Attorney

[ ] Other (Specify): _____

2) Questions to clarify grievance:

Court service, program or activity: _____

Case Number(s) (if any):_____

Date(s) of alleged discrimination: _____

Time(s) of alleged discrimination: _____

Location(s) of the alleged discriminatory act(s) (courthouse/courtroom):

Please describe the way in which you believe you have been denied a benefit, service, program or activity of the Court, or have otherwise been subject to discrimination as a person with a disability by the court. (Please attach any and all documentation that you believe to be relevant to this grievance.) _____

_____

_____

_____

Please state, if known, the names or position of any Circuit Court employees involved in the incident, as well as names, addresses and telephone numbers of any witnesses. (Please attach any and all documentation that you believe to be relevant to this grievance.)

_____

_____

_____

3) How would you like to be contacted about and informed of the resolution of this grievance:
[ ] Phone [ ] Writing [ ] Email [ ] Other (Specify): _____

(Complete Number 4 if different from Number 1 above):
4) Person who submitted this Form:

Name: _____

Address: _____

E-mail: _____ Telephone/TTY Number: _____

Telephone/TTY Number: _____

Select one of the following options:
[ ] Defendant [ ] Litigant/Party [ ] Witness [ ] Victim [ ] Juror [ ] Attorney

[ ] Other (Specify): _____

By signing below, I attest that the information I have provided on this form is accurate, true and correct to the best of my knowledge.

Signature: _____ Date: _____

Please submit this form in person or by mail or by email to:
Court Disability Coordinator (CDC)
400 West State Street, Room 215
Rockford, Illinois 61101
msmith@17thcircuit.illinoiscourts.gov

If you need help completing this form, please ask for assistance by calling the Court Administration Office at 815-319-4806 and asking for the Court Disability Coordinator. Alternative means of submitting a grievance will be made upon request. The CDC will provide a response to a grievance within 14 calendar days from the date the grievance was received.

Response to Grievance:

Date Grievance Received: _____

Resolution: _____

_____

_____

By: _____ _____
Court Official / ADA Coordinator Date