


**Thruway
Authority**

P.O. Box 189
Albany, NY 12201-0189
Phone No.: (518) 436-3083
Email: accommodations@thruway.ny.gov

AMERICANS WITH DISABILITIES ACT COMPLAINT

Purpose: This form is used to file a complaint based on disabilities in the provision of services, activities, programs or benefits.

INSTRUCTIONS: Please submit this form to the Director of Equal Employment Opportunity and Diversity Development (EEODD) at the mailing or email address above.

Section I Complainant Information

Name (Last, First, MI)		Home Phone No. () -	Email Address	
Mailing Address	City	State	Zip Code	

Section II Details of Claim

Location(s) and date(s) of the circumstances giving rise to your complaint?

Are the circumstances of your complaint continuing? Yes No

Please describe the alleged denial of services, activities, programs or benefits and your reason(s) for concluding that the conduct was discriminatory. Please include the name(s) of witnesses, if any, and attach supporting documentation, if available.

Have you filed a claim regarding this complaint with a federal, state or local government agency? Yes No

Have you hired an attorney with respect to the allegations in the complaint? Yes No

Have you instituted a legal suit or court action regarding this complaint? Yes No

This complaint form was completed by: EEODD Complainant

Signature

Date