STATE OF ALASKA **DEPARTMENT OF CORRECTIONS**

AMERICANS WITH DISABILITIES ACT COMPLIANCE PROGRAM
INTERNAL COMPLAINT FORM

I. Complainant

Name: _____

Mailing Address: _____

_____

Relationship to the Department of Corrections:

__ Employee __ Under Supervision __ Member of the Public

Telephone:

Work: _____

Home: _____

II. Nature of Complaint

Description of alleged discriminatory practice or action:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date(s) on which the alleged discrimination occurred: _____

Names of people (including witnesses) involved in the alleged discriminatory practice or act, including addresses and telephone numbers if known:

1. _____
2. _____
3. _____
4. _____
5. _____

III. Relief Sought

_____

_____

_____

_____

_____

_____

Signature: _____ **Date:** _____