City of Galt
ADA DISABILITY ACCESS or TITLE 24 ACCESSIBILITY COMPLAINT FORM

Name: ____

Address:____

City: ________________________________ State:__________ Zip: ______________

Phone: (______) __________________Email: __________________________

Type of Complaint (Check One)

Program Access ☐ **Physical Access** ☐ **Employment Discrimination** ☐ **Other** ☐

Please provide description of your complaint:_____________________________________

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Please specify the location of your complaint:_____________________________________

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Please state what you think should be done to resolve the complaint:___________________

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Attach additional pages or photo(s) as needed.

Signature: ____ Date:___________________

Please return to:
City of Galt, Human Resources Department
380 Civic Drive, Galt, CA 95632 Ph# (209) 366-7103