BOE-351 (S1F) REV. 2 (6-23)

AMERICANS WITH DISABILITIES ACT (ADA) GRIEVANCE FORM

STATE OF CALIFORNIA
BOARD OF EQUALIZATION

INSTRUCTIONS

This is a fillable, printable form. Please complete, print, sign, and send the form to: State Board of Equalization, Equal Employment Opportunity Office, P.O. Box 942879, Sacramento, CA 94279-0073. Or you may send a completed and signed electronic copy of the form via email to: EEO@boe.ca.gov.

GRIEVANT INFORMATION

GRIEVANT		
ADDRESS		
CITY	STATE	ZIP CODE
HOME TELEPHONE (*include area code*)	BUSINESS TELEPHONE (*include area code*)	

PERSON ALLEGING DISABILITY ACCESS VIOLATION

(*if other than grievant*)

NAME		
ADDRESS		
CITY	STATE	ZIP CODE
HOME TELEPHONE (*include area code*)	BUSINESS TELEPHONE (*include area code*)	

CALIFORNIA STATE BOARD OF EQUALIZATION (BOE)
SERVICE, PROGRAM, OR FACILITY ALLEGEDLY IN VIOLATION

NAME		
ADDRESS		
CITY	STATE	ZIP CODE
DATE ALLEGED VIOLATION OCCURRED	BUSINESS TELEPHONE (*include area code*)	

DESCRIPTION OF ALLEGED VIOLATION AND REQUESTED REMEDY

Has a complaint concerning this matter been filed with the Department of Justice or another government agency or court?

☐ Yes ☐ No

COMPLETE THE FOLLOWING IF YOU ANSWERED "YES" ON THE PREVIOUS QUESTION

AGENCY OR COURT WHERE COMPLAINT WAS FILED

CONTACT PERSON AT AGENCY

ADDRESS

CITY	STATE	ZIP CODE

TELEPHONE (*include area code*)

DATE FILED

OTHER COMMENTS (*please include name, address, and telephone number of legal representative, if applicable*)

SIGNATURE	DATE

CLEAR PRINT