OFFICE OF CONGRESSIONAL WORKPLACE RIGHTS

OFFICE OF THE GENERAL COUNSEL

Request for ADA Inspection

DO NOT WRITE IN THIS SPACE
Case No.
Date Filed

VERSION 2019.03 Page 1

I am requesting this inspection because I believe that access to a public service, program, activity, accommodation or facility covered by the Congressional Accountability Act has been or is being denied to persons with disabilities.

I ☐ wish to ☐ do not wish to remain anonymous.

IF YOU WISH TO REMAIN ANONYMOUS, YOUR NAME WILL NOT BE REVEALED TO OTHERS UNLESS YOU TELL US OTHERWISE.

Description of how access is being denied. Describe the public service, program, activity, accommodation, or facility and explain how access has been or is being denied to persons with disabilities.

INCLUDE A DESCRIPTION OF ANY BARRIERS ENCOUNTERED (SUCH AS PROBLEMS ENTERING A BUILDING OR AREA, COMMUNICATION DIFFICULTIES, OR ANY OTHER WAYS PARTICIPATION IN OR USE OF THE SERVICE, PROGRAM, ACTIVITY, OR ACCOMMODATION WAS LIMITED) AND PROVIDE OTHER DETAILS SUCH AS THE DATES AND LOCATIONS WHERE ACCESS WAS OR IS BEING DENIED. ADDITIONAL OR SUPPORTING INFORMATION MAY BE ATTACHED.

☐ Encountered Problems Entering or Using a Facility, Building, or Other Area.
☐ Encountered Communication Problems.
☐ Encountered Other Access Problems.

Describe location (building name, street address, room number or area):

Date(s) problems were encountered:

Describe the service, program, activity, or accommodation:

Describe the problems encountered:

Do the barriers to access described above continue to exist? ☐ Yes ☐ No ☐ I don't know

If they continue, how often is access being denied? ☐ Continually ☐ Daily ☐ Weekly ☐ Monthly

☐ Other frequency _____ ☐ I don't know

This form is considered to be a charge of discrimination under Section 210 of the Congressional Accountability Act when it is filed with the General Counsel by a qualified individual with a disability.

Room LA 200, Adams Building • 110 Second Street, SE • Washington, DC 20540-1999 • t/202.724.9250 • f/202.426.1663 • tdd/202.426.1912

www.ocwr.gov

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Office(s) responsible for providing access. ONLY IF KNOWN (NOT MANDATORY).	**Representative(s)** from these offices. ONLY IF KNOWN (NOT MANDATORY).
	Name Phone ( )
	Name Phone ( )
	Name Phone ( )

Have you told anyone affiliated with the responsible office(s) about the problems encountered? ☐ Yes ☐ No
If yes, please describe who was contacted, how contact was made (i.e., in person, or by telephone, email or letter) and what information was exchanged. THIS INFORMATION IS NOT MANDATORY

Your Name and Contact Information

Name

Work Phone ( )
Home Phone ( )
Cell Phone ( )
Other Phone ( )
Work Email
Home Email

Mailing Address

Street Name and Number

Apartment or Suite Number

City, State, Zip Code

THIS ADDRESS WILL BE USED FOR PROVIDING YOU WITH CORRESPONDENCE AND OUR FINDINGS. IT WILL NOT BE SHARED IF YOU REQUEST ANONYMITY.

Are you the person with a disability who had been denied access in the manner described above? ☐ Yes ☐ No

If you answered no, please describe why you have filed this request (i.e., concerned member of the public, affiliated with a disability rights group, caregiver, related to a person with a disability, etc.). THIS INFORMATION IS NOT MANDATORY.

I certify under penalty of perjury that the foregoing is true and correct to the best of my information and belief.
Signature _____ Date_____.

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