



DEPARTMENT OF TESTING & DISABILITY SERVICES

DISABILITY SERVICES GRIEVANCE FORM

Please complete this form to summarize the accessibility or accommodation issue(s) you are experiencing.

NAME:

ID #:

TECH E-MAIL:

PHONE:

NAME OF FACULTY/STAFF INVOLVED:

DATE OF GRIEVANCE:

DESCRIBE IN DETAIL THE NATURE OF THE GRIEVANCE. ATTACH ADDITIONAL PAGES IF NECESSARY AND BE SURE TO INCLUDE A COPY OF ANY WRITTEN CORRESPONDENCE.

Signature:

Date:

Important: If you do not receive an email confirmation from Disability Services within 24 hours from the time you submitted this form online, please contact our office at 318-257-4221.

RESOLUTION of GRIEVANCE: (After action has been taken by Disability Services)

Please keep on file. No other action requested.

Testing & Disability Services has resolved the matter to my satisfaction.

I request that Testing and Disability Services forward my grievance and any associated correspondence to the ADA Coordinator for review.

Signature:

Date: