City of Quincy

TITLE II AMERICANS WITH DISABILITIES ACT

REQUEST FOR REASONABLE ACCOMMODATION FORM

Instructions: If you or someone you know requires auxiliary aids and/or services to participate in City of Quincy sponsored programs, services, or activities, then please complete this form and return it to the address on page 3.

The City of Quincy does not charge a fee for providing auxiliary aids and/or services to e3nable someone with a disability to participate in a City of Quincy program, service, or activity.

The Americans with Disabilities Act does not require the City of Quincy to take any actionthat would fundamentally alter the nature of its programs, services, or activities, or impose an undue financial or administrative burden.

THIS FORM MUST BE SUBMITTED AT LEAST 72 HOURS (3 DAYS) PRIOR TO THE PROGRAM, SERVICE, OR ACTIVITY TO ENSURE ACCOMMODATION.

PERSON WHO REQUIRES ACCOMMODATION

Name_____

Street Address_____
City_____ State_____ Zip_____

Telephone (Daytime)(____) _____ - _____ (Evening)(____) _____ - _____

What is the Nature of your Disability and how does it limit one or more major life activities?____
_____
_____

INDIVIDUAL COMPLETING FORM:
(Complete ONLY if the form is being completed by a person other than the individual requiring accommodation)

Name_____
Title_____

Firm_____
Address_____
City_____ State_____ Zip_____

Telephone (Daytime)(____) _____ - _____ (Evening)(____) _____ - _____

ACCOMMODATION:

PLEASE DESCRIBE THE ACCOMMODATION THAT YOU ARE REQUESTING_____

_____

_____

WHAT IS THE NAME OF THE CITY OF QUINCY DEPARTMENT RESPONSIBLE FOR THE PROGRAM, ACTIVITY, OR SERVICE?

MAIL TO:
STEPHANIE BOORMAN
ADA COORDINATOR
PO BOX 338
QUINCY, WA 98848

OR

DELIVER TO:
QUINCY CITY HALL
104 B ST SW
QUINCY, WA 98848