



CLARK COUNTY  
DEPARTMENT OF BUSINESS LICENSE  
SECTION 504 REHABILITATION ACT of 1973  
COMPLAINT FORM

(Return completed form to ADA Liaison: Kathleen Rodriguez [Kathleen.Rodriguez@ClarkCountyNV.gov](mailto:Kathleen.Rodriguez@ClarkCountyNV.gov)  
(702) 455-2745 FAX (702) 678-5232 [or 711 for TTY or other Relay Services]

(PRINT OR TYPE)

YOUR NAME:

ADDRESS: STREET

APT.

CITY/STATE

ZIP

WORK TELEPHONE # (IF APPLICABLE)

HOME TELEPHONE #

**COUNTY EMPLOYEES ONLY:**

1. Name of your department and immediate supervisor: \_\_\_\_\_  
\_\_\_\_\_

2. Your present classification: \_\_\_\_\_

How long: \_\_\_\_\_

**COUNTY EMPLOYEES AND PRIVATE CITIZENS:**

1. Name of the department/individual your complaint is against: \_\_\_\_\_  
\_\_\_\_\_

2. When did the alleged discrimination occur? (Date): \_\_\_\_\_  
\_\_\_\_\_

3. This is a complaint of a disability discrimination based upon the failure to provide the following accommodation for County Programs, and/or services:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

