

Americans with Disabilities Act Complaint Form

For Staff Completion Only

Date Received: ____/____/____

Received by: _____

Date of Resolution: _____

Please complete all boxes and sections on the information form. Print or type all entries.

PERSON MAKING THE COMPLAINT:

Last Name: _____

First Name: _____

M.I: _____

Address: _____

Your Home/Cell phone: (____) ____-_____

Your Work number: (____) ____-_____

Email Address: _____

What is the best way to contact you? Home Phone Cell Phone Work
Phone Mail Email Other: _____

What is the best time to contact you? _____

Check: Yes ____ No ____: I require an accommodation for filing and resolving my complaint. Please contact me at the phone numbers and email addresses I listed to make accommodation arrangements.

DETAILS OF COMPLAINT

Date of Incident: ____/____/____

Court
Location _____

Identify the person and/or division in the Court

Please describe the concern in your own words. Use the back of the form if additional space is needed. Attach any letters or other documentation that detail the issues. Please be as specific as possible, including all names and dates.

DESIRED RESOLUTION

In your opinion, what action should be taken by the Court to resolve this matter?

HOW YOUR COMPLAINT IS HANDLED

The vision of the New Mexico Courts is to be an efficient and fair forum built on a foundation of integrity and administered by a team committed to efficient, timely, and innovative services. To this end, any complaint received by the Court will be processed in a timely manner. Complaints are processed in the order that they are received or by degree of severity. Each complaint is reviewed and investigated by a supervisor or designee. The outcome of the investigation or resolution will be disclosed to the person making the complaint.

FOR STAFF COMPLETION ONLY:

Investigation Date: ____/____/____

Resolution Date: ____/____/____

Complainant contacted and informed of resolution Yes/ No

Date Contacted: _____

Reason complainant not contacted:
