**Section 1540.APPENDIX A Grievance Form**

**Grievance**

**Discrimination Based on Disability**

It is the policy of the State Employees' Retirement System to provide assistance in filling out this form. If assistance is needed, please ask:

State Employees' Retirement System, ADA Coordinator

2101 S. Veterans Parkway, P. O. Box 19255

Springfield IL 62704

217-785-7444, 217-785-7218 (TDD)

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| City, State and Zip Code: |  |
| Telephone No.: |  |
| Program, Service or Activity to which Access was Denied or in which Alleged Discrimination |
| Occurred: |  |
| Date of Alleged Discrimination: |  |
| Nature of Alleged Discrimination: |  |

(Attach additional sheets, if necessary, and copies of any documents received or submitted to the System that pertain to the program, activity or service referred to in this grievance. If the grievance is based on a denial of requested reasonable modification, please fill out the back of this form.)

I certify that I am qualified or otherwise eligible to participate in the program, service or activity and the above statements are true to the best of my knowledge and belief.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature |  | Date |

Please give to the ADA Coordinator at the address listed above.

(Source: Added at 34 Ill. Reg. 8313, effective June 10, 2010)