EXHIBIT D.3
STATE OF ILLINOIS
TENTH JUDICIAL CIRCUIT MARSHALL COUNTY

American with Disabilities Act
Grievance Form

Date: ____________________________

Name of grievant: ____

Address: ____

Daytime Phone Number: __________________________ E-mail: _________________________
____

Type of accommodation requested: ____
____

Description of the alleged violation (please be specific): ______________________________
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Please send a copy of the completed grievance form to:

Marshall County Courthouse
Court Disability Coordinator
520 Sixth Street
Lacon, IL 61540
Or by e-mail to: wstrawn@marshallcountyillinois.com
Phone: (309) 246-2115 TDD: (800) 526-0844

Signature: ____

Print Name: ____

Date: ____