

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

Request for Accommodation under the Americans with Disabilities Act
(REQUEST TO REMAIN CONFIDENTIAL)

Date: _____

Please print:

Name of person requesting accommodation: _____

Address: _____

Daytime phone number: _____ E-mail: _____

Type of accommodation requested (please be specific): _____

Date accommodation is needed: _____

Location where accommodation is needed: _____

Please send a copy of the completed form by mail 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

Please sign to verify the foregoing information: _____

Please print name: _____

Office Use Only:

Accommodation: _____ granted: _____ denied: _____

Requestor notified on: _____ via: _____

Type of Accommodation: _____

Comments: _____