



## Americans with Disability Act (ADA) Complaint Form

**Date of Occurrence:** Click or tap to enter a date.

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**Your Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Email:** \_\_\_\_\_

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**Please provide an address or description of the location in the complaint:**

**Please provide a complete description of the specific complaint:**

I affirm under the penalty of perjury that the information provided is true to the best of my knowledge. I understand that all the information I provide becomes a matter of public record after filing.

**Please return the completed form to:**

City of Duvall  
PO Box 1300  
15535 Main Street NE  
Duvall, WA 98019  
425.788.3434 ext. 8040  
[transportation@duvallwa.gov](mailto:transportation@duvallwa.gov)

Please attach additional pages as necessary