State of Hawaii
The Department of Budget and Finance
The Americans with Disabilities Act – Title II
Grievance Form

COMPLAINANT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____

PHONE NUMBER: _____

COMPLAINT SUMMARY
(Provide details of date, time, place, people involved, witnesses and circumstances):

_____

_____

_____

_____

_____

REQUESTED REMEDY
(Provide corrective action or remedies you are seeking):

_____

_____

_____

The information provided above is truthful and accurate to the best of my knowledge.

Complainant's Signature: _____ Date: _____

Mail To:

State of Hawaii - The Department of Budget and Finance
Human Resources Office
Attn: Lori Ikenaga
250 S. Hotel St., Suite 307
Honolulu, HI 96813