Cerebral Palsy of Tri-County
1401 W. Austin
Webb City, Missouri 648870
4177-673-4940

Title VI Complaint Form

(Please print or type)

Name of Complainant Date Submitted

Please provide a detailed description, including the date, time, and place the alleged discrimination occurred. Please note bus number and staff member's name if possible. Please provide names of witnesses or other persons, including contact information, with relevant information concerning the alleged discrimination. Contact on this agency's part would be for clarification of information provided, if needed.

Signature of Complainant Date signed