

## Appendix A – Disability Complaint Reporting Form

Name of Carrier: \_\_\_\_\_

Submission Date: \_\_\_\_\_

Contact Person: \_\_\_\_\_  
Period of Data Collection: \_\_\_\_\_

Name: \_\_\_\_\_

Telephone # (include country code if outside the U.S.): \_\_\_\_\_

Email address: \_\_\_\_\_

Mailing address: \_\_\_\_\_

---

---

Total number of complaints (i.e., incidents):

# REPORT OF DISABILITY-RELATED COMPLAINT DATA

[illegible]