Miami-Dade County Homeless Trust
GRIEVANCE COMMITTEE REQUEST FORM

Date: ______________________________

COMPLAINANT INFORMATION

Your Name: ____________________________________________________
(First) (Last) (Middle Initial)
Address: ________________________________________________________
(Street) (Apt. #)
(City) (County) (State) (Zip Code)
Telephone: (Mobile) _________________________
(Other) ___________________________
ALLEGATIONS

Explain your complaint against the attorney in as much detail as possible. When did you retain the attorney? How much did you pay? What legal services did the attorney agree to perform for you? What did the attorney actually do for you? What conduct did the attorney commit that you believe is improper? Send this office COPIES of all documents that you believe support your claim, with the names and addresses of any witnesses. (Please use a pen with black ink. If necessary, continue your narrative on a separate sheet of paper.)

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Please Sign Here

Note: Unsigned complaints will not be processed.