



**DISABILITY QUESTIONNAIRE
(EMPLOYMENT CASES)**

Broward County Civil Rights Division
115 South Andrews Avenue, Room A680
Fort Lauderdale, FL 33301
Telephone: (954) 357-7800 FAX: (954) 357-7817 / TDD:(357) 357-6181
<http://www.broward.org/civilrights/welcome.htm>

In order to process and further investigate your complaint of employment discrimination, we need your help in answering each of the following questions. These questions relate to how they apply to you as a person who has a disability, and who is filing a claim of discrimination under Broward County's Equal Employment Ordinance (Chapter 16 ½) and the Americans with Disabilities Act (ADA). (These questions also apply to a disabled person whom you may be assisting in filing a complaint, or if you are filing a complaint because you have suffered discrimination because you are associated with a person who is disabled.) If you do not understand any question or if you need assistance in preparing your response, please contact a Civil Rights Intake Officer at 954-357-6050.

NOTE: This document will be made available in an alternate format to any person who needs an accommodation. Requests for an alternative format document should be made to the Civil Rights Division at the above telephone number.

PERSONAL INFORMATION:

1. My name is: _____
(First) (Middle Name or Initial) (Last)
2. I reside at _____
in the City of _____ County of _____
State of _____ Zip Code _____
3. My day time telephone number, including the area code is: _____
4. My evening telephone number, including the area code is: _____

INFORMATION ABOUT YOUR DISABILITY:

Under the County's and the Americans with Disabilities Act (ADA), a person is considered disabled if they meet one of the definitions listed below.

For each definition, please state whether or not you believe it applies to you or the person(s) that you are assisting in filing a complaint, or the person with whom you are associated.

1. Do you (or the person you are assisting) have a physical or mental impairment? Yes No

2. Describe this physical or mental impairment.

3. As a result of a physical or mental impairment are you substantially limited in performing one or more life activities? Yes No

4. Which of the following major life activities does your disability impair?

[Note: Please check all boxes that apply.]

Seeing

Reaching

Hearing

Breathing

Speaking

Learning

Walking

Sitting

Taking care of oneself

Lifting

Working

Other? Please describe:

Performing Manual Tasks

Standing

5. What percentage (%) of your job requires the activity or activities that you have identified in response to question #4, above?

Less than 10% _____

More than 10% but less than 33% _____

More than 33% but less than 50% _____

More than 50% _____

6. Are you disabled as a result of a work-related injury?

Yes No

7. Is your disability permanent?

Yes No

8. If you answered "No" to question 7, how long is your disability expected to persist?

9. Is there a record or a history of such physical or mental impairment which limits one or more major life activities?

Yes No

10. What is (was) your job title? _____

11. Describe your job duties/responsibilities: _____

12. Do you believe that your employer knows about your disability?

Yes No

13. Did you request that the employer make any accommodations for you because of your disability?

Yes No

14. If you requested an accommodation, what was it? _____

When did you make the request? _____

Was it a written or verbal request? _____

To whom did you make the request? _____

15. What was the employer's response to your request for an accommodation?

16. Please indicate what you think the employer needs to do to enable you to perform your job:

- Assign part of your job duties to a co-worker
- Make certain facilities accessible
- Purchase or change equipment
- Reassign you to a vacant position
- Change your work schedule
- Change a company policy
- Other: (Specify) _____

17. Additional comments, if any:

18. Please provide copies of any medical (or social service agency) documentation which substantiates the existence of your disability and the extent to which you are limited in performing daily major life activities.

Under penalty of perjury, I declare that I have read the entire contents of this Questionnaire and that my answers and statements contained herein are true and correct.

Signed: _____

Printed Name: _____

Date Signed: _____