Office Use ONLY
Date Received: ___/___/___
ADA Case No: _____

Professional Standards/Human Rights Section
Broward County Governmental Center
115 South Andrews Avenue, Suite 427, Fort Lauderdale, FL 33301
Phone: 954-357-6500 TTY: 954-357-7888 Fax: 954-357-7889

ADA ACCOMMODATION QUESTIONNAIRE

Last Name: First Name: Middle Initial:

Home Ph. #: Work Ph. #: Cell Ph. #:

Home Address: Apt./Unit #:

City: State: Zip Code:

Job Title: Email Address:

Department: Division:

Supervisor's Name: Supervisor's Title:

Work Ph. # Department: Division

What is your impairment?

Are you currently under the care of a healthcare provider(s) for the impairment for which you are seeking this workplace accommodation? ○ Yes ○ No

If yes, please provide all healthcare provider(s) information.

Healthcare Provider(s) Name Phone Number

Healthcare Provider(s) Name Phone Number

Please Note: An "Authorization for Release of Health Information" Form (attached) is required for each treating Healthcare Provider for which you are seeking this workplace accommodation.

Broward County will not pay fees that are requested/imposed by your Healthcare Provider(s) in completing the Broward County Physician's ADA Questionnaire.

Check those activities substantially affected by your impairment: **(Please check all that apply)**

☐ Walking ☐ Seeing ☐ Working ☐ Lifting ☐ Manual Tasks ☐ Standing

☐ Breathing ☐ Speaking ☐ Hearing ☐ Sitting ☐ Learning ☐ Caring for oneself

☐ Other (please specify)

What, if any, medical treatment do you receive for your impairment?

Does your treatment necessitate taking time off work? ○ Yes ○ No

How much time?

Have you applied for the Family Medical Leave Act (FMLA)? ○ Yes ○ No

When were you approved for FMLA?

When did your FMLA expire?

Are you currently on a reduced schedule? ○ Yes ○ No

What type of leave are you using?
(i.e. sick leave, FMLA, leave without pay, annual leave, donated leave)

What is your reduced work schedule?

How long do you expect to maintain a reduced work schedule?

What is your regular work schedule?

List specific job duties affected by your impairment.

Explain how your impairment affects these job duties:

Is there any accommodation that would enable you to perform those duties affected by your impairment? ○ Yes ○ No

If you answered yes to the previous question, please explain in detail:

Have you discussed these with your supervisor before now? ○ Yes ○ No

What was their response?

Have any modifications to your job, job duties, or work environment already been provided? ○ Yes ○ No

What are they?

Is your impairment a result of a work-related incident/accident? ○ Yes ○ No

Provide the date the work-related incident/accident occurred:

Did you file a workers' compensation claim? ○ Yes ○ No

Who is your workers' compensation adjuster?

Are you on light duty as a result of the incident/accident? ○ Yes ○ No

Please describe the light duties/activities you are currently performing below.

By signing this document, I declare that I have completed this form in good faith and my answers and statements contained herewith are true and correct based on my current knowledge. Since it is necessary to engage with Broward County staff in this interactive process together, I will respond promptly to any communications received from the Professional Standards/Human Rights Section relating to this request.

Printed Name

Sign and Date

Please return completed form to the Broward County Professional Standards/Human Rights Section