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

Print Form

Office of Intergovernmental Affairs and Professional Standards
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:

Date of Birth (mm/dd/yyyy):

Job Title:

Office/Department/Division:

Supervisor's Name: Supervisor's Title:

Work Ph. #

What is your medical condition/impairment?

Are you currently under a healthcare provider's care for your medical condition/impairment? ◯ Yes ◯ No

If yes, please provide your healthcare provider's information.

Healthcare Provider's Name Phone Number

Please Note: Healthcare provider's contact information is required on the "Authorization for Release of Health Information" form.

Broward County will not pay fees that are requested/imposed by your healthcare provider in completing the ADA Physician's Questionnaire.

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

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

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

☐ Other (please specify)

Explain how your medical condition/impairment affects the activities you checked above:

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

Does your treatment necessitate taking time off from work? ◯ Yes ◯ No

If yes, how much time?

Are you currently on a reduced schedule or leave? ◯ Yes ◯ No

If yes, what type of leave are you using?

If yes, what is your work schedule?

List specific job duties affected by your medical condition/impairment:

Explain how your medical condition/impairment affects these job duties:

What modifications to your job duties or work environment would allow you to perform the above-listed job duties?

Is there any type of device that would enable you to perform those duties affected by your medical condition/impairment?

◯ Yes ◯ No

If yes, please explain in detail:

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

If yes, what are they?

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

If yes, what was the response?

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

If yes, is there a worker's compensation claim? ◯ Yes ◯ No

If yes, who is your workers' compensation adjuster?

Are you on light duty as a result of the incident? ◯ Yes ◯ No

Please describe the light duty 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.

Printed Name

Signature and Date

Please return completed form to **Office of Intergovernmental Affairs and Professional Standards**