

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

**REASONABLE ACCOMMODATION RECOMMENDATION FORM
AMERICANS WITH DISABILITIES ACT**

_____ **Employee** _____ **Program Participant** _____ **Candidate for Employment**

Name and Address of Individual Requesting Reasonable Accommodation:

Position Title, Position Applied for, or Program Request of Individual requesting accommodation:

Work Location of Requesting Individual: (DOH Employees only)

Reason for Accommodation request:

- _____ Application Process
- _____ Performing position functions or work environment accessibility
- _____ Access to a benefit, privilege of employment or CHD/CMS (e.g. attending a training program, department social event, or clinic appt.)

Date reasonable accommodation request was submitted: _____

Name and Title of individual receiving the request:

Reasonable Accommodation Recommendation:

_____ **Approve** (state accommodation that was approved)

_____ **Deny** (state reason for denial)

_____ **Recommended Alternative Accommodation** (see below)

Type(s) of alternative reasonable accommodation recommended (if different from what was requested):
(attach additional sheets if necessary)

Name and Title of Delegated Authority: _____

Date of decision: _____
(approved, denied, or alternative accommodation recommended)

Was medical documentation submitted as support for this request? _____ yes _____ no

What sources of technical assistance, if any, were used in trying to identify possible reasonable accommodations? (e.g. disability organization, JAN/Job Accommodation Network):

Comments:

Signature of Delegated Authority:

Date: _____

Phone: _____