

**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 REQUEST FORM  
AMERICANS WITH DISABILITIES ACT**

\_\_\_\_\_ **Employee**      \_\_\_\_\_ **Program Participant**      \_\_\_\_\_ **Candidate for Employment**

**Name:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Home or Cell Phone No:** \_\_\_\_\_

**DOH Work Address:** \_\_\_\_\_

**DOH Work Phone No:** \_\_\_\_\_

**DOH Work Location/Bldg:** \_\_\_\_\_

**Position Title:** \_\_\_\_\_

**My specific disability and/or limitation is:**

\_\_\_\_\_

**The accommodation being requested is:** (Be as specific as possible, e.g. adaptive equipment, interpreter, reader, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The reason why the accommodation is being requested:** (Describe the nature of the physical or mental impairment and how it affects your ability to perform the essential job duties of your position): Submit a copy of your position description to this request. (Attach additional sheets if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**EMPLOYEE/CLIENT/APPLICANT CERTIFICATION**

I certify that I have a medical condition that requires a reasonable accommodation, which can be met by acquiring the equipment, services, or work adjustments described above. I give the Department of Health permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act (ADA). This includes permission to obtain relevant medical records. I understand that all information obtained during this process will be maintained and used in accordance with confidentiality requirements.

**Signature:**

**Date:** \_\_\_\_\_