

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)

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: _____