ACCOMMODATION REQUEST FORM

DOH-Broward does not discriminate on the basis of differing ability in admission to, or operation of its programs, services, activities or facilities. This form may be used by individuals and their companions with a differing ability seeking access to a Florida Department of Health in Broward County program, service, activity, or facility.

ACCOMMODATION REQUEST INFORMATION

Name: _____ Telephone (or TTY):_____
Address: _____ Date: _____

The program or facility to which I am requesting access is located at:

_____

I am requesting the following accommodation(s): Check

- ☐ Wheelchair Access
- ☐ Sign Language Interpretation
- ☐ Translation Services
- ☐ Written Material in Alternate Format (i.e. Large Print, Computer Disc)
- ☐ Written Material in Braille
- ☐ Reader
- ☐ Modification of Policy Procedures
- ☐ Other

Specify other: _____

Date and time accommodations are needed: _____

_____

Please provide any other details or information necessary to process this request:

_____

Thank You.

PLEASE RETURN THIS FORM TO THE PERFORMANCE IMPROVEMENT DEPARTMENT TWO WEEKS BEFORE EVENT

DOH-Broward, Attn: Performance Improvement Department
780 SW 24th Street
Fort Lauderdale, FL 33315
(954) 467-4700 Ext. 5270
Fax: 954-467-4785