



# 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 (TTY or VP): \_\_\_\_\_  
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 \_\_\_\_\_

Date and time accommodations are needed: \_\_\_\_\_  
\_\_\_\_\_

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

Staff originating request: Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Service Provider has been contacted. Appointment date & time confirmed. Purchase Order (PO) has been created. PO # \_\_\_\_\_.

Staff creating PO: Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

DOH-Broward, Attn: Performance Excellence Department  
780 SW 24<sup>th</sup> Street  
Fort Lauderdale, FL 33315  
(954) 467-4700  
Fax: 954-467-4785