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.

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 24th Street
Fort Lauderdale, FL 33315
(954) 467-4700
Fax: 954-467-4785

DOH-Broward A/64 (Rev. 05/16)