REQUEST FOR ACCOMMODATION

Name: ______________________________________

Phone Number:

(Home):________________________

(Cell):__________________________

(Work):_________________________

Home Address: ____

Employee ID: _________________________

Work Location: ________________________________

Date disability occurred: _______________________

Description of specific on-the-job duties or other job-related activities the disability prevents you from performing:

Description of all accommodations which you feel would allow you to perform the essential functions of the job:

Listing of all relevant health care providers, including names, office addresses, and telephone numbers:

*Attach any supporting documentation that may be helpful in evaluating this request for accommodation.

Please return the completed form to the CMO - Office of Professional Standards:

101 NE 3rd Ave, Fort Lauderdale, FL 33301

Suite 1400

954-828-4934 (Office Phone)

Equalopportunity@fortlauderdale.gov

Thank you in advance for your prompt reply to the questions in the attached provider questionnaire.