

**FLORIDA DEPARTMENT OF CORRECTIONS  
REASONABLE MODIFICATION OR ACCOMMODATION REQUEST**

**This form is not to be used to request medical devices, medical passes or to request any type of medical care. These issues must be directed to the medical department in accordance with chapter 33-103. This form is to be used to request access to the department's services, programs or activities only.**

You may use this form to request specific reasonable modification or accommodation which, if granted would enable you to participate in a service, activity or program offered by the Department/Institution/Facility, for which you are otherwise qualified/eligible to participate.

Submit this completed form to the Institution or facility's ADA Intake Officer (Asst. Warden for Programs or other designee). A decision will be rendered within 10 days of receipt at the Intake Officer's office and the completed form will be returned to you. If the decision made regarding your request is a denial or a modification of the original request this form will be sent to the Central Office ADA Coordinator for his/her review. If the ADA Coordinator concurs with the Intake Officer's decision you will be notified within 10 days of receipt of the form in the ADA Coordinator's Office. If the ADA Coordinator does not agree with the decision, after consultation with the appropriate directors, you will be notified within 20 days of the decision rendered in Central Office.

If you are not satisfied with the ADA Coordinator's review decision you may follow the Inmate Grievance Procedure and will be given an extension of the time required to file a formal grievance alleging a violation of the ADA.

\_\_\_\_\_  
Inmate Name (Print)

\_\_\_\_\_  
DC#

\_\_\_\_\_  
Institution/Facility

**MODIFICATION OR ACCOMMODATION REQUESTED**

Description of disability: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What verification do you have of your disability? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What specific modification or accommodation is required? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Inmate Signature

\_\_\_\_\_  
Date Signed

**REVIEWER'S ACTION**

**TYPE OF ADA ISSUE:**

- Program Service or Activity Access (not requiring structural modification)
- Auxiliary Aid or Device Requested
- Physical Access (requiring structural modification)
- Other \_\_\_\_\_

Discussion of Findings: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date Inmate Was Interviewed

\_\_\_\_\_  
Person Who Conducted Interview

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**DISPOSITION**

\_\_\_\_\_ Granted                  \_\_\_\_\_ Denied                  \_\_\_\_\_ Modified/Partially Granted

Basis of Decision: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note:** If disposition is based upon information provided by other staff or other resources, specify the resource or staff and the information provided below. If the request is granted, specify the process by which the modification or accommodation will be provided, in the space below, with time frames if appropriate.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Disposition Rendered By

\_\_\_\_\_  
Title

\_\_\_\_\_  
Institution/Facility

\_\_\_\_\_  
Date Returned to Inmate