FLORIDA DEPARTMENT OF CORRECTIONS
REASONABLE MODIFICATION OR ACCOMMODATION REQUEST
INSTITUTIONAL EVALUATION/DISPOSITION

(FOR STAFF USE ONLY)

Inmate Name: Last Name, First Name ______________________________ DC#: ________________

Date Received: ____________ Institutional ADA Log No.: ____________ Institution: ______________

EVALUATION OF REQUEST

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______________________ Evaluation Date

______________________ Staff Signature

Return completed form to the warden or intake officer for institutional disposition upon completion of medical evaluation.
If evaluation is not required, mark N/A in this section.

INSTITUTIONAL DISPOSITION

☐ Approved ☐ Denied ☐ Modified/Partially Approved ☐ Returned Without Action (Non-ADA Issue)

Basis of Decision: ____

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______________________ Disposition Rendered By (Signature)

______________________ Disposition Date

______________________ Disposition Rendered By (Printed Name & Title)

Distribution for the Completed Form with Disposition:
CO-ADA Coordinator
Health Services (Inmate's Health Record)
File