DISABILITY QUESTIONNAIRE (EMPLOYMENT CASES)

Palm Beach County Office of Equal Opportunity
301 North Olive Avenue, 10th Floor --- West Palm Beach, FL 33401
Telephone: (561) 355-4883 / FAX: (561) 355-4932 / TDD: (561) 355-1517
http://www.co.palm-beach.fl.us

In order to process and further investigate your complaint of employment discrimination, we need your help in answering each of the following questions. These questions relate to how they apply to you as a person who has a disability, and who is filing a claim of discrimination under Palm Beach County's Equal Employment Ordinance and the Americans with Disabilities Act (ADA). (These questions also apply to a disabled person whom you may be assisting in filing a complaint, or if you are filing a complaint because you have suffered discrimination because you are associated with a person who is disabled.) If you do not understand any question or if you need assistance in preparing your response, please contact an OEO Intake Technician at (561) 355-4883.

NOTE: This document will be made available in an alternate format to any person who needs an accommodation. Requests for an alternate format document should be made to the Office of Equal Opportunity at the above telephone number.

PERSONAL INFORMATION:

1. My name is: _____
   (First) (Middle Name or Initial) (Last)

2. I reside at _____

   in the City of _____ County of _____

   State of _____ Zip Code _____

3. My day time telephone number, including the area code is: _____

4. My evening telephone number, including the area code is: _____

INFORMATION ABOUT YOUR DISABILITY:

Under the County's Equal Employment Ordinance and the Americans with Disabilities Act (ADA), a person is considered disabled if they meet one of the definitions listed below.

For each definition, please state whether or not you believe it applies to you or the person(s) that you are assisting in filing a complaint, or the person with whom you are associated.

1. Do you (or the person you are assisting) have a physical or mental impairment? Yes ○ No ○

2. Describe the physical or mental impairment?

3. As a result of a physical or mental impairment are you substantially limited in performing one or more major life activities? ○ (Yes) ○ (No)

4. Which of the following major life activities does your disability impair?

[Note: Please check all boxes that apply.]

- ☐ Seeing
- ☐ Hearing
- ☐ Speaking
- ☐ Walking
- ☐ Taking care of oneself
- ☐ Working
- ☐ Performing Manual Tasks
- ☐ Standing
- ☐ Reaching
- ☐ Breathing
- ☐ Learning
- ☐ Sitting
- ☐ Lifting
- ☐ Other? Please describe:

_____

_____

5. What percentage (%) of your job requires the activity or activities that you have identified in response to question #4, above?

Less than 10% ____
More than 10% but less than 33% ____
More than 33% but less than 50% ____
More than 50% ____

6. Are you disabled as a result of a work-related injury?

Yes ____ No ____

7. Is your disability permanent ?

Yes ____ No ____

8. If you answered "No" to question 7, how long is your disability expected to persist?

9. Is there a record or a history of such physical or mental impairment which limits one or more major life activities?

Yes ____ No ____

10. What is (was) your job title? _____

11. Describe your job duties/responsibilities: _____

_____

_____

12. Do you believe that your employer knows about your disability?

Yes ____ No ____

13. Did you request that the employer make any accommodations for you because of your disability? Yes ____ No ____

14. If you requested an accommodation, what was it? _____

_____.

When did you make the request? _____

Was it a written or verbal request? _____

To whom did you make the request? _____

15. What was the employer's response to your request for an accommodation?

_____

_____

17. Please indicate what you think the employer needs to do to enable you to perform your job:

- ☐ Assign part of your job duties to a co-worker
- ☐ Make certain facilities accessible
- ☐ Purchase or change equipment
- ☐ Reassign you to a vacant position
- ☐ Change your work schedule
- ☐ Change a company policy
- ☐ Other: (Specify) _____.

18. Additional comments, if any:

19. Please provide <u>copies</u> of any medical (or social service agency) documentation which substantiates the existence of your disability and the extent to which you are limited in performing daily major life activities.

Under penalty of perjury, I declare that I have read the entire contents of this Questionnaire and that my answers and statements contained herein are true and correct.

Signed: _____

_____

_____Printed Name: _____

Date Signed: _____