ADA ACCOMMODATION REQUEST FORM

Tallahassee Orthopaedic Clinic, LLC, d/b/a Florida Orthopaedic Institute ("THE PRACTICE")

Effective Date:
Return to: 1557/ADA Coordinator- Jennifer Corbin, jcorbin@ortho-solutions.com
Patient Information:
Full Name:_____
Date of Birth:_____
Email (optional):_____
Preferred Contact Method (Phone, Patient Portal, Email, Mail, Other):_____

Visit Information:

- Date of Scheduled Appointment (if applicable):_____
- Practice Location:_____
- Provider/Department:_____

Accommodation Request:

☐Mobility assistance (wheelchair access, transfer help, accessible exam table)
☐ Assistance completing forms or reading written materials
☐Large-print materials
☐Braille Materials
☐Digital or screen-reader-friendly files (email or USB)
☐Sign language interpreter (ASL, SEE, or Other)
☐ Large screen
☐ Assistive listening device or captioning service
☐ Extended appointment time or flexible scheduling
☐ Service animal access
☐ Other (please describe):_____

Patient Signature: _____ Date:_____

Staff Signature: _____ Date: _____

___ If patient is unable to sign due to disability, please select here and document patient's verbal agreement along with a witness signature below.

Witness Signature: _____ Date: _____