



MILWAUKEE COUNTY DEPARTMENT OF HUMAN RESOURCES DECA SUPPLEMENT

Please complete all sections. Section A is to be completed by the applicant and Section B by the physician or counselor. Upon completion, return it to Department of Human Resources, 901 N 9th St, Room 210, Milwaukee, WI 53233. Applications can also be submitted by Email to Susan.Chase@milwaukeecountywi.gov or Fax to 414-223-1379

SECTION A (To be completed by the applicant/DECA candidate)

_____	_____	_____
First Name	M. I.	Last Name

_____	_____	
Phone	Email Address	

The following information is being requested on a voluntary basis. The information will be kept confidential and will be used in accordance with Title I of the ADA (P.L. 101-336). This information is also being requested voluntarily as Milwaukee County is taking affirmative action pursuant to Section 503 of the Rehabilitation Act of 1973.

A qualified individual is considered disabled if s/he has:

- (A) a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or
- (B) a record of having such an impairment
- (C) being regarded as having such an impairment

Additionally, the individual should be capable of performing the essential functions of a job when provided with reasonable accommodation.

Do you fit this definition? _____ Yes _____ No

If yes, what are your handicapping conditions? _____

An individual with a severe disability is one in which the individual is unable to perform, or must have personal assistance in order to perform one or more of the major life activities (self-care, manual tasks, walking, seeing, hearing, speaking, breathing, learning, working, sitting, standing, lifting, thinking, concentrating, and interacting with others).

Do you consider yourself severely disabled? _____ Yes _____ No

If Yes, please indicate which major life activities are impacted by your disability:

- | | | | | | | |
|-----------------|-------------------|-------------|--------------|-------------|--------------|---------------|
| ___ Self-Care | ___ Manual Tasks | ___ Walking | ___ Seeing | ___ Hearing | ___ Speaking | ___ Breathing |
| ___ Learning | ___ Concentrating | ___ Sitting | ___ Standing | ___ Lifting | ___ Thinking | ___ Working |
| ___ Interacting | | | | | | |

What types of personal assistance/equipment do you require? _____

What accommodations would you require at the worksite? _____

List three areas of occupational interest. _____

The information supplied is true and to the best of my knowledge

Applicant Signature _____ Date _____

I understand and agree, that, as a DECA candidate, I may be placed on a viable list for the positions I apply for without an actual score or rank. I will instead be certified as a DECA eligible for possible appointment without the benefit of test results, which are scored and ranked by the department of Human Resources.

Applicant Signature _____ Date _____

SECTION B (To be completed by Counselor or Physician)

Please verify the disability and any functional limitations for the applicant to the Milwaukee County Disabled Expanded Certification Appointment (DECA) program.

Counselor _____ Physician _____
 Agency/School _____ Address _____
 Address _____ City _____
 City/State/Zip _____ State/Zip _____

Please indicate the major life activities which the individual is unable to perform, or must have personal assistance in order to perform:

___ Self-Care ___ Manual Tasks ___ Walking ___ Seeing ___ Hearing ___ Speaking ___ Breathing
 ___ Learning ___ Concentrating ___ Sitting ___ Standing ___ Lifting ___ Thinking ___ Working
 ___ Interacting

Please indicate the type of personal assistance/equipment that is required: _____

Applicant is able to:

	Never	(1-33%) Occasionally	(34-66%) Frequently	(67-100%) Continuously
Push/pull-seated	_____	_____	_____	_____
Push/Pull-standing	_____	_____	_____	_____
Bend	_____	_____	_____	_____
Climb	_____	_____	_____	_____
Crawl	_____	_____	_____	_____
Squat	_____	_____	_____	_____
Reach above shoulder level	_____	_____	_____	_____

LIFT:	Never	(1-33%)	(34-66%)	(67-100%)	CARRY:	Never	(1-33%)	(34-66%)	(67-100%)
0-10#	_____	_____	_____	_____	0-10#	_____	_____	_____	_____
11-24#	_____	_____	_____	_____	11-24#	_____	_____	_____	_____
25-34#	_____	_____	_____	_____	25-34#	_____	_____	_____	_____
35-50#	_____	_____	_____	_____	35-50#	_____	_____	_____	_____
51-74#	_____	_____	_____	_____	51-74#	_____	_____	_____	_____
75-100#	_____	_____	_____	_____	75-100#	_____	_____	_____	_____

	<u>Hours</u>									Continuously	With Rests
Sit	0	1	2	3	4	5	6	7	8	_____	_____
Stand	0	1	2	3	4	5	6	7	8	_____	_____
Walk	0	1	2	3	4	5	6	7	8	_____	_____

HANDS:	Simple Grasping		Firm Grasping		Fine Manipulation		Push/Pull	
Right	___ Yes	___ No	___ Yes	___ No	___ Yes	___ No	___ Yes	___ No
Left	___ Yes	___ No	___ Yes	___ No	___ Yes	___ No	___ Yes	___ No

Restriction of Activities:

	None	Mild	Moderate	Total
Unprotected heights	_____	_____	_____	_____
Being around moving machinery	_____	_____	_____	_____
Exposure to marked temperature changes	_____	_____	_____	_____
Driving automotive equipment	_____	_____	_____	_____
Exposure to dust, fumes, gases	_____	_____	_____	_____

Counselor/Physician Signature _____ Date _____

DEPARTMENT OF HUMAN RESOURCES USE ONLY

DECA Eligible: _____ Yes _____ No
 Date: _____
 Disability: _____
 Initials: _____