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:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Continuously</th>
</tr>
</thead>
<tbody>
<tr>
<td>Push/pull-seated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Push/Pull-standing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bend</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climb</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crawl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Squat</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reach above shoulder level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LIFT:  
0-10# Never (1-33%) (34-66%) (67-100%) CARRY: 0-10# Never (1-33%) (34-66%) (67-100%)

11-24#       25-34#       35-50#       51-74#       75-100#

<table>
<thead>
<tr>
<th>Hours</th>
<th>Continuously</th>
<th>With Rests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sit</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td></td>
</tr>
<tr>
<td>Stand</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td></td>
</tr>
<tr>
<td>Walk</td>
<td>0 1 2 3 4 5 6 7 8</td>
<td></td>
</tr>
</tbody>
</table>

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

Restriction of Activities:

<table>
<thead>
<tr>
<th>Unprotected heights</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being around moving machinery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to marked temperature changes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driving automotive equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to dust, fumes, gases</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Counselor/Physician Signature ___________________________ Date ___________

DEPARTMENT OF HUMAN RESOURCES USE ONLY

DECA Eligible: _______ Yes _______ No

Date: ___________________________

Disability: ___________________________

Initials: ___________