

State of Illinois - Disability Hiring Survey

Name: _____ Agency: _____ Date: _____ Last 4 of SSN: _____

The purposes of this survey are to collect affirmative action statistics and to identify emergency evacuation needs. Any information provided will be accorded confidentiality and will be used in compliance with state and federal Equal Opportunity Non-Discrimination laws. Information submitted in relation to emergency evacuation needs will be shared with safety personnel.

* Indicates Required Fields

I. Do you have a disability as defined below?

- Yes
 No

II. If yes, identify which disability you have. Indicate as many as three.

- Are you blind or do you have serious difficulty seeing even when wearing glasses?
- Are you deaf or do you have serious difficulty hearing?
- Do you have serious difficulty walking or climbing stairs?
- Do you have difficulty dressing or bathing?
- Due to a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?
- Due to a physical, mental, or emotional condition, do you have difficulty doing errands such as visiting a doctor's office or shopping?
- Other (Examples, Epilepsy, Heart Condition, Mental Illness, Multiple Sclerosis, Muscular Dystrophy)?

* If "Other" Please Indicate: _____

III. Do you need assistance in the event of an emergency evacuation because of your disability?

- Yes
 No

* Suggested Assistance: _____

Other Concerns:
(Visual, Auditory,
Mobility, etc.)

* Please Provide Your Work County:

Work County: _____

* Please Provide Work Address:

Work Address: _____

Employee Signature:
