Section 504 ADA Accommodation Request Form

STATEMENT

Pursuant to Section 504 of the Rehabilitation Act of 1973, *et al,* the Pleasantville Public Schools ("District"), will provide reasonable accommodations for (a) its qualified, disabled employees, provided the employees can perform the essential functions of their respective jobs, and (b) all other applicants that, by law, the District is required to accommodate. The information provided will be kept confidential and will be shared on a need to know basis only.

INSTRUCTIONS

The individual requesting an accommodation must file this form with the Director of Human Resources along with supporting medical documentation. The supporting medical documentation must include the following:

(1) diagnosis; (2) prognosis; (3) anticipated length of disability;
(4) description of the requested accommodation; and
(5) the original signature of the diagnosing physician.

The applicant may wish to submit the supporting medical documentation directly to:

Pleasantville Public Schools
Office of Human Resources
801 Mill Road, 3rd Floor
Pleasantville New Jersey 08232

Upon receipt of the fully executed application, the accommodation request will be reviewed in a timely manner. The Director of Human Resources will notify the applicant in writing of the determination.

For: _____

Date: _____

1. Applicant's Information

Name_____, _____, _____
Last *First* *Middle Initial*

Home Address_____, _____
Residence Number and Street Name *Apt. #, Floor, etc.*

_____ _____ _____
City *State* *Zip Code*

Home Phone_____ Mobile Phone _____
Area Code and Number *Area Code and Number*

E-mail Address _____

IF APPLICANT IS A DISTRICT EMPLOYEE:

Work Location_____
School Name, Dept., etc.

Title_____ Work Phone_____
Area Code and Number

Supervisor _____

2. Medical Authorization

By execution of this application, I hereby authorize the use and/or disclosure of my health information to the relevant District staff. I further authorize the District's physician to communicate with my physician, care-taker, and/or the like in an effort to receive further information concerning my request for accommodation.

I understand that I have the right to revoke this authorization at any time by notifying the Director of Human Resources in writing of the revocation.

I understand that revocation is only effective after it has been received by the District's designee(s).

I understand that any use or disclosure made prior to revocation under this authorization will not be affected by a revocation.

I understand that after this information is disclosed, it may no longer be protected by federal and/or state privacy laws and the recipient may disclose it.

I understand that I am entitled to receive a copy of this authorization.

I understand that this authorization expires when (if I am a District employee) my employment is terminated, or as otherwise noted below:

Applicant's Signature _____ Date_____

Printed Name of Applicant _____
First, Middle Initial, Last Name

3. Job Description (if a District employee)

Please provide a detailed description of the nature and responsibilities of your position with the District. The description must include, as a minimum, your work hours, whether you are a 10 or 12 month employee, and your duties.

4. Claimed Disability and Requested Accommodation

Please explain in detail the nature of applicant's claimed disability, and the accommodation requested. Such information must include any and all reasonable accommodations needed. Attach additional documents as necessary.

5. Additional Comments

Please use the remaining space if you wish to include comments regarding this application that have not been previously addressed.

Signature of Applicant _____ Date: _____