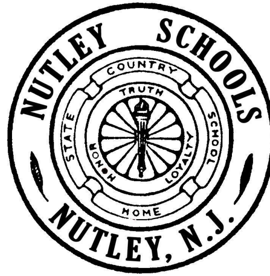

Section 504 ADA Accommodations Request Form

____

(Printed Name of Applicant)

STATEMENT

Pursuant to Section 504 of the Rehabilitation Act of 1973, et al., the Nutley Public Schools ("District"), will provide reasonable accommodations for its qualified, disabled employees, provided the employees can perform the essential functions of their respective jobs. The information provided will be kept confidential and will be shared on a need to know basis only.

INSTRUCTIONS

The employee requesting an accommodation must file this form with the District Office 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 employee can submit the supporting medical documentation directly to kgreco@nutleyschools.org

Upon receipt of the fully executed application, the accommodation request will be reviewed in a timely manner. An individual meeting to discuss your request will be set up, then submitted to the superintendent and district medical doctor for review and next steps determined.

Section 504 ADA Accommodation Request Form

1. Applicant's Information

Name ______________, ______________, _________
(Last) (First) (Middle Initial)

Home Address ____________ ______________

___________________ _________ ____________
(City) (State) (Zip Code)

Home Phone _____________________ Mobile Phone _________________

E-mail Address ____

Work Location _________________________________
(School Name, Dept., etc.)

Title _______________ Work Phone ___________________________

Signature of Applicant _____________________ _______________
(Date)

2. Medical Authorization

By execution of this application, I hereby authorize the use and/or disclosure of my health information. I understand that I have the right to revoke this authorization at any time by notifying the District's 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 my employment is terminated, unless otherwise noted here ________________ (expiration date).

Applicant's Signature __________________________ Date _______

Printed Name of Applicant ____
(First, Middle Initial, Last Name)

3. Job Description

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.

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5. Additional Comments

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

***********************THIS PAGE IS FOR INTERNAL USE ONLY****************

1. MEDICAL DEPARTMENT/HEALTH SERVICES Comments/Acknowledgement:

______________________________________ ___________________________
(Signature of Authorized Representative) (Date)

2. ___________________________(Comments/Acknowledgment)

______________________________________ ___________________________
(Signature of Authorized Representative) (Date)

3. ______________________________________
Comments/Approval/Disapproval:
(Subject-Matter Expert)

______________________________________ ___________________________
(Signature of Authorized Representative (Date)

4. 504 Accommodation Officer Comments/Approval/Disapproval:

______________________________________ ___________________________
(Signature of Authorized Representative) (Date)