

**ORANGE PUBLIC SCHOOLS
ADA/NJLAD EMPLOYEE ACCOMMODATION REQUEST**

The Orange Public Schools pursuant to Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, ADA/New Freedom of Initiatives, Title VII of the Civil Rights Act of 1964 amended by the Equal Opportunity Commission and Title I of the ADA will, in good faith, provide reasonable accommodations for its qualified employees. The OPS may require additional information in order to consider when to provide a reasonable accommodation and when to be interactive with certain parties in an effort to determine what, if any, accommodations should be provided. The OPS will regard the dissemination of information in order to make determination regarding accommodations on a “need to know basis”. In addition, the OPS will act in a timely manner on such requests for accommodation. It should be noted information submitted is kept in confidence.

INSTRUCTIONS:

OPS employees requesting accommodation as a result of a medical condition must file this ADA/NJLAD 504 Accommodation Request Form and submit supporting medical documentation to the Office of Human Resources for review and consideration. Thereafter, the Executive Director of Human Resources will convene the 504 Committee to address this request.

Please note that Section 1, entitled “Applicant’s Information,” must be signed by the applicant’s Supervisor. The applicant must submit the request, supported with the necessary medical documentation that includes: diagnosis, prognosis, time period in which the applicant seeks an accommodation, and a detailed description of the accommodation being requested.¹

To protect the applicant’s privacy rights, the 504 Committee respectfully requests that the supporting medical documentation be submitted directly to the Office of Human Resources, Attention Glasshebra Jones Dismuke, 451 Lincoln Avenue, Orange, NJ 07050. Upon receipt and acknowledgement of the fully executed request, the 504 Committee will review the request in an effort to make a determination as to whether the requested accommodation is “reasonable” and “feasible”. Upon such determination, the 504 Committee will notify all interested parties of its determination in a timely manner. Please complete the attached application. Print clearly where applicable.

After submitting this form and supporting medical documentation, the applicant must provide, in writing, his/her availability for a meeting to discuss this request with the Executive Director of Human Resources and 504 Committee Members and/or District Administration. At the time of this meeting, the applicant must bring a union or legal representative or provide, in writing, why he/she has elected to represent him/herself.

¹ The request for documents means ALL documents related to this request. A one (1) page “prescription” or “return to work” form is insufficient. You MUST produce all underlying medical documentation related to your request.

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SECTION 1:

Name: _____ **Date:** _____

Address: _____ **Phone:** _____

City: _____ **Zip Code:** _____

Department: _____ **Title:** _____

Location: _____ **Phone:** _____

Applicant's Signature: _____

Supervisor's Signature: _____

Supervisor's Name: _____ **Phone:** _____

Date: _____

SECTION 2:

MEDICAL AUTHORIZATION/WAIVER

By way of execution of this Confirmation of Accommodation Request Form and the Medical Release Form (attached to this application), I hereby authorize the use/or disclosure of my health information to the members of the Orange Public Schools ADA/NJLAD 504 Accommodation Committee and grant this waiver for a period of ninety (90) days from the below date of execution. I understand that I have the right to revoke this authorization at any time by notifying the District, in writing, of the revocation to the attention of Glasshebra Jones Dismuke, Executive Director of Human Resources.

I understand that revocation is only effective after it is received and recorded by the District. 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:** _____

Print Name: _____

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MEDICAL RELEASE FORM

Date: _____

I _____ hereby authorize _____
Employee Name Patient's Physician or Medical Facility
to release the following information.

() All Medical Records or () _____

I understand this information is confidential and, in accordance with HIPPA laws, is to be held as such by the recipient of this information.

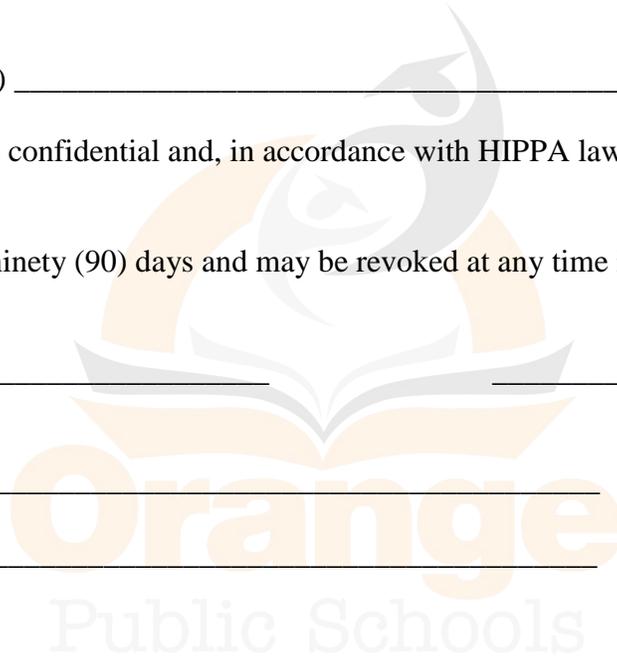
This authorization is valid for ninety (90) days and may be revoked at any time in writing prior to the expiration date.

Patient's Signature

Date

SS#: _____

Date of Birth: _____





ORANGE TOWNSHIP SCHOOL DISTRICT
OFFICE OF HUMAN RESOURCES

504 Accommodation Request
CONFIDENTIAL DOCUMENT

Print Employee Name (last, first, middle)

Assignment/Title

Department

Facility

- | | |
|---|---|
| <input type="checkbox"/> Orange High School | <input type="checkbox"/> Stem Academy |
| <input type="checkbox"/> Orange Preparatory Academy | <input type="checkbox"/> Orange Alternative Program |
| <input type="checkbox"/> Orange Early Childhood Center | <input type="checkbox"/> Scholars Academy |
| <input type="checkbox"/> Heywood Avenue School | <input type="checkbox"/> Forest Street Community School |
| <input type="checkbox"/> Rosa Parks Community Elementary School | <input type="checkbox"/> Lincoln Elementary School |
| <input type="checkbox"/> Cleveland Elementary School | <input type="checkbox"/> Park Avenue Elementary School |
| <input type="checkbox"/> Oakwood Elementary School | <input type="checkbox"/> Other Facility _____ |

1. Please describe the limitation you are addressing: _____

2. How does your disability affect the essential functions of your job? _____

3. Do you have a suggestion on an accommodation? Yes No

If yes, please describe: _____

Please describe how you will benefit from it: _____

4. Is your request as a result of a pandemic? Yes No

If so, please specify _____

Other Employee Comments: _____

- I have attached a completed Physician's Certification form.
- The Physician's Certification is being sent under separate cover.
- I have not yet seen my physician. My appointment is _____ / _____ / _____
mm dd yyyy

If you have any questions regarding my request, please contact me at: (_____) _____

Employee Signature Date

Attach any relevant documentation or additional information which you believe may be of assistance in the accommodation review process and return to Ms. Shebra Jones Dismuke, Executive Director of Human Resources.

A REQUEST WILL NOT BE CONSIDERED WITHOUT SUPPORTING MEDICAL DOCUMENTATION

HR USE ONLY:

Received by: _____ Date: _____