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. All information submitted will be confidential.

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 Nancy Masoud, 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:	_____	**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 Nancy Masoud, 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: _____

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504 Accommodation Request

CONFIDENTIAL DOCUMENT

Last Name First Name Assignment/Title

Location:

□ Orange High School

□ Orange Preparatory Academy

□ Orange Early Childhood Center

□ Heywood Avenue School

□ Rosa Parks Community Elementary School

□ Cleveland Elementary School

□ Oakwood Elementary School

□ Stem Academy

□ Orange Alternative Program

□ Scholars Academy

□ Forest Street Community School

□ Lincoln Elementary School

□ Park Avenue Elementary School

□ Other Location/Department

1. Please describe the limitation you are addressing:

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

3. Do you have any suggestions on accommodations? □ Yes □ No If yes, please describe:

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CONFIDENTIAL DOCUMENT

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:

Phone number: _____

Email: _____

_____

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. Nancy Masoud, Executive Director of Human Resources.

A REQUEST WILL NOT BE CONSIDERED WITHOUT SUPPORTING MEDICAL DOCUMENTATION

HR USE ONLY:

Received By: _____ Date: _____