PASSAIC COUNTY COMMUNITY COLLEGE

Reasonable Accommodation Request Form

The College requires the completion of this form to assist it in assessing your request for a reasonable accommodation. This initial information will be part of an interactive process with you as we explore your request. This form will be kept separate from your personnel file. Your responses may generate the need for additional information.

Employee Name: _____

Dept.: _____ Job Title: _____

Work Phone: _____ Home Phone: _____

This section is to be completed by an **Employee** requesting a reasonable accommodation.

What limitation(s) is interfering with your job performance or accessing a benefit of employment?

_____

_____

What job function(s) or benefits of employment are you having difficulty accessing because of that limitation(s)?

_____

_____

How does your limitation(s) interfere with your ability to perform your job function(s) or access a benefit of employment?

_____

_____

Describe any suggested accommodation(s) that you believe will assist you in addressing the above referenced limitation(s):

_____

_____

Explain how that suggested accommodation(s) will assist you:

_____

_____

If applicable, identify the source and/or cost (if known) for providing the accommodation(s):

_____

_____

I authorize the release of necessary confidential medical information regarding my disability to relevant hiring managers as deemed necessary by Human Resources. I also attest to the fact that a copy of the positon description has been given to me for review and reference.

Employee signature: _____ Date: _____

This section is to be completed by the Employee's treating physician:

Medical Certification for ADA Reasonable Accommodation Instructions:

This form is designed to identify the medical condition/symptoms and restrictions/limitations prohibiting an employee from performing certain essential functions of his/her position.

Employee Name: _____

Medical Professional's Certification

Please state the diagnosis and provide a description of the employee's medical condition symptoms that support the restrictions listed above:

_____

_____

Please indicate employee's job-related restrictions:

_____

_____

_____

If use is restricted, list restrictions: _____

Use of special/modified equipment/devices, explain: _____

_____

_____

_____

I certify that the information provided is an accurate and complete representation of the patient's work reasons for said restrictions.

Medical Professional's Printed Name: _____

Medical Professional's Signature: _____

Date: _____

Medical Professional's Degree & License: _____

Medical Professional's Business Name & Address:

_____

_____

_____

Return this completed form to:

DEPARTMENT OF HUMAN RESOURCES
Attn: Associate Director for Human Resources
One College Blvd.
Paterson, New Jersey 07505

Fax: 973-684-5072
Email: aconte@pccc.edu

GINA DISCLAIMER

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.