DEPARTMENT OF SERVICES FOR PERSONS WITH DISABILITIES

CITY OF NEW HAVEN
165 CHURCH STREET
NEW HAVEN, CONNECTICUT 06510
(203) 946-8122 - VOICE (203) 946-8582 - TTY/TT
(203) 946-6934 - FAX

Promoting Accessibility In New Haven

APPLICANT ADA ACCOMMODATION REQUEST FORM

ACCOMMODATION REQUESTS MUST BE FILED WITH THE DEPARTMENT OF SERVICES FOR PERSONS WITH DISABILITIES WITHIN 15 BUSINESS DAYS OF THE JOB POSTING REMOVAL DATE

APPLICANT'S NAME: _____ DATE: _____

ADDRESS: _____

PHONE: _____

TEST DATE: _____

POSITION: _____

The Americans with Disabilities Act (ADA) enables qualified applicants with substantial impairments that effects one or more major life activities the opportunity to request a reasonable modification to the City's policies, practices and procedures to enable them to apply and/or test for a position with the City. We will need from the applicant information related to his or her disability to determine what accommodation may be best for the applicant.

What you need to know about the accommodation process:

1. All information provided to the Department of Services for Persons with Disabilities is confidential and will only be used to provide an appropriate accommodation to applicants with disabilities whom have requested an accommodation.
2. Most applicants who request an accommodation will be asked to submit medical documentation to verify that they are a person with a disability as defined in the ADA.
3. Individuals requesting an accommodation for a learning disability will need to provide documentation from a health care provider describing the type of learning disability.
4. All information and documentation submitted from a health care provider must be written within the previous twelve (12) months to the date of application to insure that the accommodation meets the current needs of the applicant.
5. Any health care provider used to support this application must be willing and able to speak knowledgeably about the disability and willing to work with our staff in determining the best accommodation for the applicant.
6. All supporting documentation must be presented no later than 15 days after the job posting "REMOVAL DATE."

To process your request for an accommodation we need the following information:

DESCRIBE YOUR HEALTH ISSUE, DIAGNOSIS OR IMPAIRMENT: _____

DESCRIBE HOW YOUR HEALTH ISSUE OR IMPAIRMENT AFFECTS YOUR LIFE: _____

DESCRIBE WHAT ACTIVITIES IN YOUR DAILY LIFE ARE RESTRICTED BY YOUR HEALTH ISSUE OR IMPAIRMENT: _____

WHAT ACCOMMODATIONS DO YOU FEEL WILL ENABLE YOU TO APPLY FOR AND/OR TEST FOR THIS POSITION WITH THE CITY. PLEASE DESCRIBE IN DETAIL. _____

PLEASE PROVIDE THE NAME AND PHONE NUMBER OF YOUR CURRENT TREATING HEALTH CARE PROVIDER THAT CAN SPEAK TO YOUR CURRENT LIMITATIONS. BE SURE TO CONTACT YOUR HEALTH CARE PROVIDER TO SIGN THE NECESSARY RELEASES OF INFORMATION SO THAT THIS DEPARTMENT MAY DISCUSS WITH THEM YOUR CONDITION AND WHAT ACCOMMODATIONS WILL WORK BEST. ALL MEDICAL INFORMATION PROVIDED TO THE DEPARTMENT OF SERVICES FOR PERSONS WITH DISABILITIES IS STRICTLY CONFIDENTIAL AND WILL ONLY BE USED IN EVALUATING THIS ACCOMMODATION REQUEST.

HEALTH CARE PROVIDER'S NAME: _____

PHONE: _____

I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS REQUEST IS A TRUE AND ACCURATE.

_____ DATE: _____

APPLICANT'S SIGNATURE

PLEASE DIRECT ALL QUESTIONS AND RETURN THIS FORM TO:

MICHELLE DUPREY, DIRECTOR
(203) 946-7651
TTY 946-8582
FAX 946-6934
DEPARTMENT OF SERVICES FOR PERSONS WITH DISABILITIES
165 CHURCH STREET, NEW HAVEN, CT 06510