

City of New Haven
 Dept. of Services for Persons with
 Disabilities
 165 Church Street
 New Haven, CT 06510
 (203) 946-7651
 Fax (203) 946-6934
 TTY (203) 946-8582



New Haven Public Schools
 Human Resources & Labor Relations
 54 Meadow Street
 New Haven, CT 06519
 475-220-1540

ADA ACCOMMODATION REQUEST FORM

NAME: _____ DATE: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

WHERE DO YOU WANT CORRESPONDENCE SENT? WORK HOME

JOB TITLE: _____

SUPERVISOR/DEPT. HEAD: _____

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 employees with disabilities whom have requested an accommodation.
2. Most employees 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. 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 employee.
4. 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 employee.

A. Questions to help determine whether you have a disability.

For reasonable accommodation under the ADA, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability:

Do you have a physical or mental impairment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If yes, what is the impairment?

Is the impairment long-term or permanent?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If *not* permanent, how long will the impairment likely last?

Answer the following questions based on what limitations you have when your condition is in an active state and what limitations you would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If yes, what major life activity(s) is/are affected?

<input type="checkbox"/> Caring For Self	<input type="checkbox"/> Walking	<input type="checkbox"/> Hearing	<input type="checkbox"/> Lifting	<input type="checkbox"/> Other: (describe)
<input type="checkbox"/> Interacting With Others	<input type="checkbox"/> Standing	<input type="checkbox"/> Seeing	<input type="checkbox"/> Sleeping	
<input type="checkbox"/> Performing Manual Tasks	<input type="checkbox"/> Reaching	<input type="checkbox"/> Speaking	<input type="checkbox"/> Concentrating	
<input type="checkbox"/> Breathing	<input type="checkbox"/> Thinking	<input type="checkbox"/> Learning	<input type="checkbox"/> Reproduction	
<input type="checkbox"/> Working	<input type="checkbox"/> Toileting	<input type="checkbox"/> Sitting	<input type="checkbox"/> Eating	
<input type="checkbox"/> Communicating	<input type="checkbox"/> Reading	<input type="checkbox"/> Bending		

Does the impairment substantially limit the operation of a major bodily function?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If yes, what bodily function is affected?

<input type="checkbox"/> Immune	<input type="checkbox"/> Hemic	<input type="checkbox"/> Circulatory	<input type="checkbox"/> Other: (describe)
<input type="checkbox"/> Normal Cell Growth	<input type="checkbox"/> Special Sense Organs and Skin	<input type="checkbox"/> Endocrine	
<input type="checkbox"/> Digestive	<input type="checkbox"/> Lymphatic	<input type="checkbox"/> Reproductive	
<input type="checkbox"/> Bowel	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal	
<input type="checkbox"/> Bladder	<input type="checkbox"/> Brain	<input type="checkbox"/> Special Sense	
<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Cardiovascular	

B. Questions to help determine whether an accommodation is needed.

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability:

What limitation(s) is interfering with job performance?

Will you need to be absent due to the condition?

If yes, how often will you need to be absent?

What job function(s) are you having trouble performing because of the limitation(s)?

How does your limitation(s) interfere with your ability to perform the job function(s)?

C. Questions to help determine effective accommodation options.

The following questions may help determine effective accommodations:

Do you have any suggestions regarding possible accommodations to perform the duties of your position?

If so, what are they?

D. Additional Relevant Information.

PLEASE PROVIDE THE NAME, PHONE NUMBER AND FAX OF YOUR CURRENT TREATING HEALTH CARE PROVIDER THAT CAN SPEAK TO YOUR CURRENT LIMITATIONS. BE SURE TO CONTACT YOUR HEALTH CARE PROVIDER TO NOTIFY THEM THAT THIS DEPARTMENT WILL BE CONTACTING THEM. 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: _____

ADDRESS: _____

PHONE: _____

FAX: _____

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

EMPLOYEE'S SIGNATURE

DATE: _____

IF YOU ARE AN EMPLOYEE THAT WORKS IN A NEW HAVEN PUBLIC SCHOOLS FACILITY OR ADMINISTRATION DIRECT ALL QUESTIONS AND RETURN THIS FORM TO:

**VALLERIE HUDSON-BROWN
475-220-1549
HUMAN RESOURCES & LABOR RELATIONS
54 MEADOW STREET
NEW HAVEN, CT 06519**

IF YOU ARE AN EMPLOYEE THAT WORKS FOR ANY CITY DEPARTMENT THAT IS NOT PART OF THE BOARD OF EDUCATION, DIRECT ALL QUESTIONS AND RETURN THIS FORM TO:

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