REASONABLE ACCOMMODATION REQUEST FORM

This form and all information must be kept confidential.

APPLICANT/EMPLOYEE INFORMATION	
Print Full Name:	☐ Job Applicant ☐ Current Employee ☐ Other
Home Address:	**Phone Number:** **Email Address:**

EMPLOYEE INFORMATION (Complete this section if you are working at NYC Health + Hospitals, even if you are currently on leave.)		
Corporate Title:	**Functional Title:**	
Office Telephone Number:	**Department:**	**Supervisor Name and Phone Number:**
Facility/Location:		

APPLICANT INFORMATION (Complete this section only if you are a job applicant.)	
Position/Title Sought:	**Division/Department:**
Facility/Location:	**Job Code (if known):**

Reasonable Accommodation being requested:

Basis of Reasonable Accommodation Request:

☐ Disability

☐ Pregnancy, Childbirth or a related medical condition

☐ Status as Victim of Domestic Violence, Sex Offenses, or Stalking

NOTE (for Victim of Domestic Violence, Sex Offenses, or Stalking): To request a reasonable accommodation, you may be required to provide certification that you are a victim of domestic violence, sex offenses or stalking. A person may satisfy the certification requirement of this paragraph by providing documentation from an employee, agent, or volunteer of a victim services organization, an attorney, a member of the clergy, or a medical or other professional service provider, from whom the individual seeking a reasonable accommodation or that individual's family or household member has sought assistance in addressing domestic violence, sex offenses or stalking and the effects of the violence or stalking; a police or court record; or other corroborating evidence.

Is the condition for which you are requesting an accommodation:

☐ **Permanent** ☐ **Temporary** ☐ **Unknown**

If temporary, anticipated date accommodation(s) no longer needed:

Describe the Requested/Suggested Accommodation(s) you believe are needed to perform the essential functions of the position held or desired, or to enjoy the benefits and privileges of employment. Please be specific.
(Attach additional sheets and present supporting documentation as appropriate.)

If equipment is requested, please specify the type of equipment needed and/or the specific type of assistance (mechanical, ergonomic, or otherwise) required for your requested accommodation.

For Reasonable Accommodations based on Disability you may be required to provide verification by a health professional.

This CONFIDENTIAL documentation should only be provided to the EEO Officer.

Documentation must:

☐ **Be written on the official letterhead of the qualified health professional or health professional's organization.**
☐ **Identify the health professional's credentials. e.g., M.D., D.O.**
☐ **Be dated and signed by the health professional.**
☐ **Describe the nature of the qualifying disability.**
☐ **Describe the severity of the disability and its limitations in detail as they currently exist and only in relationship to the job.**
☐ **State whether the duration of disability is permanent or temporary or unknown.**
☐ **If temporary, specify the date the disability is expected to no longer require accommodation.**
☐ **Indicate the extent to which the accommodation will permit you to perform the essential functions of the job or to enjoy the benefits and privileges of employment. It is suggested that you provide a copy of your functional job description to your health care provider to assist in the determination of whether or not you can perform the essential functions of your job with or without a reasonable accommodation. If you need a copy of your functional job description, you can request a copy from the EEO Officer and/or Human Resources.**

Please note that failure to provide the appropriate documentation, which includes all of the above information, could result in a denial of your reasonable accommodation request until such information is provided. Additionally, if you wish for this office to contact your medical provider directly concerning your request for a reasonable accommodation, please complete the attached "Authorization for Release of Health Information Pursuant to HIPAA" Form.

I certify that I have read and understood the information provided in this request, and that it is true to the best of my knowledge, information and belief.

Date	Requestor's Signature/Authorized Agent