ADA ACCOMMODATION REQUEST FORM

Americans with Disabilities Act
Title I—Compliance Program

BRIDGEPORT
PUBLIC SCHOOLS

BOARD OF EDUCATION
City Hall- 45 LyonTerrace,
Room 324 Bridgeport, CT 06604

Name: _____

Address: _____

_____

Home Phone: _____ Work Phone: _____

Position Applied for or Currently Held: _____

Department: _____ Supervisor: _____

Accommodation Requested (e.g. ramp over stairs, change to work schedule, ergonomic chair)

_____

_____

_____

_____

Execution of this document means that the Bridgeport Board of Education has received such document and it will be processed. You will be notified of either approval/denial of your request once a decision is made.

Employee Signature _____ Date _____

BOE/HR Rep _____ Date _____

The Bridgeport Board of Education will consider your request and attempt to a make reasonable accommodation. However, the final decision to grant or deny the accommodation request remains at the sole discretion of the City of Bridgeport/BOE

"THE BRIDGEPORT BOARD OF EDUCATION IS AN EQUAL OPPORTUNITY EMPLOYER"

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City Hall- 45 LyonTerrace,
Room 324 Bridgeport, CT 06604

Accommodation Request Procedures

1. Accommodation requests should be made in writing. ***Contact the Department of Human Resources, Room 324. To schedule an appointment call 203-275-1042.***

2. If you have current medical documents concerning your potential disability, please bring them with you to the appointment.

3. The Department of Human Resources will document your request and answer any questions you may have. You will receive a brochure explaining your rights and responsibilities.

4. You will be asked to sign a "*Consent to Release Information"* form. The consent form will be used to obtain an official copy of personnel and/or medical documents relevant to the disability in question.

5. Upon receipt of the medical information describing the claimed disability, the accommodation request is forwarded to the appropriate authority for a decision.

6. When a determination is made you will be notified of the decision in writing.

I acknowledge, that I have read and understand the Bridgeport Board of Education's Americans with Disabilities Act (ADA) Accommodation Procedures above.

_____ _____

Employee Signature Date

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ADA ACCOMMODATION CONSENT TO RELEASE INFORMATION

Americans with Disabilities Act
Title I—Compliance Program

BRIDGEPORT
PUBLIC SCHOOLS

BOARD OF EDUCATION
City Hall- 45 LyonTerrace,
Room 324 Bridgeport, CT 06604

I_____ of _____
(Employee Name) (Address)

give_____ of _____
(Doctor's Name) (Practice/Specialty)

permission to disclose the following information to the Department of Human Resources for the Bridgeport Board of Education.* This information should include a diagnosis, prognosis, and physician summary statement of the medical condition.

By executing such document I also authorize access to my Personnel, or any other employee file which contains information, medical or otherwise, that is necessary and relevant to determining a reasonable accommodation.

This information is to be used specifically for the purpose of determining an appropriate reasonable accommodation as required by the provisions of Title I of the Americans with Disabilities Act (ADA) Public Law 101-336.

The undersigned hereby understands that unless revoked in writing, this consent form will expire on the 180th day. Upon expiration of such 180 days a new consent form will be required by the BOE, in order for the BOE to monitor such medical condition.

I understand that I have a right to revoke this authorization at any time. I understand that the revocation is only effective after it is received and recorded and that a revocation of this authorization does not disqualify the accommodation request if it has been approved. However, I further understand that the BOE may deny the accommodation request if I have revoked this authorization and the BOE requires the disclosure of more medical information. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that I am entitled to receive a copy of this consent form.

_____ _____

Employee Signature **Date**
(or Parent or Guardian if under the age of 18)

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ADA ACCOMMODATION PHYSICIAN'S STATEMENT

Americans with Disabilities Act
Title I—Compliance Program

BRIDGEPORT
PUBLIC SCHOOLS

BOARD OF EDUCATION
City Hall- 45 LyonTerrace,
Room 324 Bridgeport, CT 06604

Name of Physician: _____

Address: _____

Practice: _____ Phone Number: _____

Please describe the employee's current medical condition and/or disability.

_____

_____

_____

_____

How long will the employee need reasonable accommodation? If unable to provide date, when will he or she be medically reevaluated?

_____

_____

Describe how the condition or disability might affect their ability to fully perform their job functions. (Please discuss with the employee to determine essential job duties.)

_____

_____

_____

_____

Describe how the condition or disability corresponds with the accommodation being requested. In addition, describe what adjustments to the work environment or position responsibilities would enable the employee to perform the essential functions of that position.

_____

_____

_____

_____

_____ _____

Signature Date

THE CITY OF BRIDGEPORT, CONNECTICUT IS AN EQUAL OPPORTUNITY EMPLOYER
MF/AA/DIS