



CITY OF JERSEY CITY DEPARTMENT OF HUMAN RESOURCES



CITY HALL | 280 GROVE STREET | JERSEY CITY, NJ 07302
P: 201 547 5217 | F: 201 547 5022

AMERICANS WITH DISABILITIES ACT ACCOMMODATION REQUEST FORM

Employee must complete this form:

Employee Name: _____ Division: _____

Address: _____

Phone Number: _____ Job Title: _____

Please provide the following information. Attach additional sheets as necessary:

1. Identify your disability or physical or mental impairment(s) and/or limitation(s):

2. Explain how your Disability impairs and/or limits your ability to perform assigned job duties:

3. What is the expected duration of the Disability: _____

4. What specific accommodation(s) are you requesting?

5. Has a health care professional recommended a specific accommodation? If so, Please describe or attach documentation:

6. How will that accommodation(s) assist you to perform the essential functions of your job?

7. Have you had any accommodations in the past for this same limitation? If yes, what were they and how did the accommodation(s) help you perform your job?

Employee Certification

I certify that I have a disability or medical condition that requires reasonable accommodation, which will be met by acquiring the equipment, services, or work adjustments described above.

Employee Signature: _____

Date: _____

The ADA Accommodation Request Form must be submitted directly to the Human Resources ADA Coordinator:
Human Resources Rm. 103
Attn: ADA\FMLA Coordinator
280 Grove Street, Jersey City, NJ 07302

PERSONAL INFORMATION NOTICE

Pursuant to the Federal Privacy Act (P.L.93-579), notice is hereby given for the request of personal information by this form. The requested personal information is voluntary. The principal purpose of the voluntary information is to facilitate the processing of this form. No disclosure of personal information will be made unless permissible. Each individual has the right upon request and proper identification, to inspect all personal information in any record maintained on the individual by an identifying particular. Direct any Inquiries on information maintenance to your ADA Coordinator.



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PROVIDER ADA ACCOMMODATION MEDICAL CERTIFICATION

Medical provider must complete this Form:

IMPORTANT NOTICE REGARDING GINA

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 employees or their family members. To comply with this law, The City of Jersey City is 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 member 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.

Employee Name: _____

Provider’s name and business address:

Type of practice/ Medical Specialty: _____

Telephone: (____) _____ **Fax:** _____

1. Please confirm you have examined the employee and are familiar with the employee’s medical history. Yes No
2. Please confirm you have reviewed the job description or equivalent for the employee. Yes No
3. Is the employee released to return to work full time, full duty without the need for accommodations, restrictions, or limitations? Yes No

If yes, please state the employee’s full, unrestricted return to work date: _____

IF NO, PLEASE COMPLETE the information below.

4. Does the employee have a physical or mental impairment(s)? Yes No

5. Check all major life activities affected by the employee's impairment(s):

General life activities:

<input type="checkbox"/> Bending <input type="checkbox"/> Breathing <input type="checkbox"/> Caring for self <input type="checkbox"/> Concentrating <input type="checkbox"/> Eating <input type="checkbox"/> Hearing	<input type="checkbox"/> Interacting with others <input type="checkbox"/> Learning <input type="checkbox"/> Lifting <input type="checkbox"/> Performing manual tasks	<input type="checkbox"/> Reaching <input type="checkbox"/> Reading <input type="checkbox"/> Seeing <input type="checkbox"/> Sitting <input type="checkbox"/> Sleeping <input type="checkbox"/> Speaking	<input type="checkbox"/> Standing <input type="checkbox"/> Thinking <input type="checkbox"/> Walking <input type="checkbox"/> Working <input type="checkbox"/> Shaving <input type="checkbox"/> Other(s):
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Operation of major bodily functions:

<input type="checkbox"/> Bladder <input type="checkbox"/> Bowels <input type="checkbox"/> Brain <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Circulatory	<input type="checkbox"/> Digestive <input type="checkbox"/> Endocrine <input type="checkbox"/> Genitourinary <input type="checkbox"/> Hemic <input type="checkbox"/> Immune	<input type="checkbox"/> Lymphatic <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Neurological <input type="checkbox"/> Normal cell growth <input type="checkbox"/> Operation of an organ	<input type="checkbox"/> Reproductive <input type="checkbox"/> Respiratory <input type="checkbox"/> Sensory organs & skin <input type="checkbox"/> Other(s):
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6. Does the employee's impairment substantially limit one or more major life activities above? Yes No

7. Please identify and describe the physical or mental impairment(s). Impairment could include an injury to the human body.

8. When did the employee's identified impairment(s) commence? If there is more than one impairment, please specify the start date for each: In other words, when did you first treat the employee for the impairment(s)?

*** NOTE:** Reasonable accommodations may include such things as a modified work schedule, provision of special equipment, workplace accessibility modifications, shifting of **non-essential** duties of the employee's position, and medical leave of absence to allow time for recovery, therapy, training, or other disability-related needs.

9. Does the employee's impairment(s) limit his/her ability to perform the essential functions of the employee's position (as defined in the job description)? Yes
No

If the answer is yes:

a. Identify which essential function(s) the employee is unable to perform:

b. Describe the manner in which the employee's ability to perform each essential function is limited:

10. Taking into consideration the nature, severity, and the duration of the impairment as well as limitations imposed by the impairment, what specific accommodation(s), if any, would you recommend for this employee? (*Note: if the accommodation request is Medical Leave of Absence, please indicate below and provide the beginning and ending dates of the leave request)

a. How the accommodation(s) will assist the employee in performing the essential job functions:

*** NOTE:** Reasonable accommodations may include such things as a modified work schedule, provision of special equipment, workplace accessibility modifications, shifting of **non-essential** duties of the employee's position, and medical leave of absence to allow time for recovery, therapy, training, or other disability-related needs.

11. How long do you anticipate the employee will need the identified accommodation(s) to perform the essential job functions (please note N/A is not acceptable)?

Day(s)_____ Week(s)_____ Month(s)_____ Year(s)_____ Permanent_____

Comments (please provide the frequency and duration for intermittent leave requests)

12. Is there any other information that should be considered with regard to this employee's ability to perform the essential job functions? Yes No

If yes, please describe:

Provider Name (print)

Phone Number

Provider Signature

Date



CITY OF JERSEY CITY
AUTHORIZATION FOR RELEASE OF
MEDICAL INFORMATION



By signing this form, I represent that I am the employee or the legal representative of the employee identified below and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the employee's behalf with respect to this authorization form.

I, _____ **HEREBY AUTHORIZE** _____
 (Employee's Name) (Name of Healthcare Provider)

to release to the **City of Jersey City** medical information pertinent to the reasonable accommodation requested in the attached document. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

To any licensed physician, other licensed practitioner, hospital, clinic, or other medically related facility, or United States Veteran Administration: I authorize you to release to the City of Jersey City the above - requested information to be used solely for the purpose of evaluating my request for reasonable accommodation. This authorization shall be valid for a period 180 days after the date of my signature or earlier if revoked by me in writing to the City of Jersey City. I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request. I further acknowledge that I have been informed that if the medical information contained herein is not released, my reasonable accommodation may be denied.

 Employee Signature

 Date



REASONABLE ACCOMMODATIONS & THE AMERICANS WITH DISABILITIES ACT

The Americans with Disabilities Act (ADA) of 1990 requires most public and private employers to provide reasonable accommodations that enable qualified people with disabilities to perform the essential functions of their jobs. As the term "reasonable" implies, the accommodation must not constitute an undue hardship to the employer. This fact sheet provides definitions of key terms and procedures related to job accommodations under the employment provisions (Title I) of the ADA.

WHO IS COVERED?

Employers: Public and private employers with 15 or more employees are required to comply with the ADA Title I provisions. The federal government, Native American Tribes, and tax-exempt private membership clubs are not covered.

Applicants: Individuals with physical or mental impairments that substantially limit functioning in one or more major life activities. Major life activities include, but are not limited to:

- walking,
- seeing,
- hearing,
- speaking,
- learning,
- working, and
- self-care

WHO IS A QUALIFIED APPLICANT?

Under Title I of the ADA, a qualified person with a disability is one who satisfies the primary requirements of the position and who can perform essential functions of the job with or without reasonable accommodations. To be eligible for reasonable accommodations, the person must have a disability and be qualified for the position that he or she seeks or holds.

WHAT ARE ESSENTIAL FUNCTIONS?

Essential job functions are those primary duties which the person must be capable of performing, with reasonable accommodations if required. These functions must be developed and be officially written into the job description. Job descriptions must be given to all prospective employees and made available to all current workers. The following are reasons under which a function may be considered essential:

- The position exists to perform the function.
- There are a limited number of other employees available to perform the function, or among whom the function can be distributed.
- The function is highly specialized, and the person in the position is hired for their special expertise or ability to perform it.

WHAT ARE REASONABLE ACCOMMODATIONS?

Reasonable accommodations are modifications to the job or to the way a job is performed that enables qualified people with disabilities to perform the essential functions of their positions. Broad categories of accommodations may include changes to: the job application process; the work environment; the way a job is usually done; and the work routine that enable an employee with a disability to enjoy equal benefits and privileges of employment (such as access to training).

Reasonable accommodations could include:

- medical leave of absence,
- restructuring of existing facilities,
- restructuring of the job,
- modification to work schedules,
- modification of equipment,
- installation of new equipment,
- provision of qualified readers and interpreters,
- modification of application and examination procedures and training materials

Reasonable accommodations DO NOT include:

- eliminating a primary job responsibility;
- lowering production standards that are applied to all employees;
- providing personal use items, as prosthetic limbs, wheelchairs, eyeglasses, hearing aids, etc.;
- anything that would be considered to be an undue hardship to the employer; and
- excusing a violation of a uniformly applied conduct rule that is job-related and consistent with business necessity. For example, that an employer never has to tolerate or excuse violence, threats of violence, stealing, or destruction of property.

WHAT CONSTITUTES AN UNDUE HARDSHIP?

An accommodation may be considered an undue hardship if it exceeds the bounds of practicality. That is, an employer would not be required to provide an accommodation if it costs more than alternatives that are equally effective, requires extensive and disruptive renovations, or negatively affects other employees or customers. Undue hardships are determined on a case-by-case basis, using the following criteria:

- the cost and nature of the accommodation;
- the overall financial resources of the facility;
- the overall financial resources of the employer; and
- the type of operation of the covered employer.

WHAT IS THE AVERAGE COST OF A REASONABLE ACCOMMODATION?

According to the Job Accommodation Network:

- 50% of accommodations cost less than \$500;
- 19% cost nothing at all;
- more than 80% cost less than \$1,000.

WHAT SHOULD AN EMPLOYEE DO TO REQUEST AN ACCOMMODATION?

The individual must let the employer know that he or she needs an adjustment or change at work for a reason related to a disability. Requests for accommodations can be done verbally or in writing.

WHAT SHOULD AN EMPLOYER DO FOLLOWING A REQUEST FOR AN ACCOMMODATION?

- (1) Verify employee's disability.
- (2) Identify essential job functions that require accommodations.
- (3) Identify a variety of accommodations to reduce and/or remove barriers and increase productivity.
- (4) Determine cost-effectiveness of each accommodation required by employee.
- (5) Implement the most appropriate accommodation with the least economic hardship.

REASONABLE ACCOMMODATION RESOURCES

Technical Assistance and Guidance

- Job Accommodation Network (JAN):
1-800-526-7234, <http://askjan.org/index.htm>
- U.S. Equal Employment Opportunity Commission:
1-800-669-4000 (TTY), <http://www.eeoc.gov>
- U.S. Department of Labor (written materials):
1-800-959-3652 (Voice), 1-800-326-2577 (TTY),
to ask questions: (202) 219-8412 (Voice)
- ADA Disability and Business Technical Assistance Centers (DBTACs): 1-800-949-4232 (Voice/TTY),
<http://www.adata.org/dbtac.htm>

