Public Schools of Plainfield

DEPARTMENT OF HUMAN RESOURCES
1200 Myrtle Avenue
Plainfield, NJ 07060
Phone: 908-731-4328 Fax: 908-731-4261

Department of Human Resources and Special Services
504 EMPLOYEE ACCOMMODATION REQUEST FROM

The Plainfield Public School District in accordance with Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 and ADA/New Freedom of Initiatives, Title VII of the Civil Rights Act of 1964 amended by the Equal Opportunity Commission and Title I of the ADA will provide reasonable accommodations for qualified employees provided the employee can perform the essential function(s) of their job.

The District will require all applicants to complete this form for accommodation requests with supporting medical documentation that must include: **1. diagnosis 2. prognosis 3. anticipated length of disability 4. description of requested accommodation. ALL requests must be submitted with the original signature of the diagnosing physician.**

This information must be submitted directly to the Myrna Dyson, R.N. Supervisor of Nursing and Health Services, 1200 Myrtle Avenue, Plainfield, NJ 07063 or mdyson@plainfield.k12.nj.us.
After submitting this form with all supporting medical documentation it will be reviewed and a determination will be made as to whether the request for accommodation is reasonable. After the determination has been reached all interested parties will be notified by Human Resources in a timely manner.

Section 1 (to be completed by employee)

Name of Employee: _____ **Position/Title:** _____

Location: _____ **Phone Number:** _____

By execution of this application, I hereby authorize the use and/or disclosure of my health information as it relates to this request to the Plainfield Board of Education's Human Resources Dept.

I understand I have the right to revoke this authorization at any time by written notice to the Human Resources Dept.
I understand that once this information is disclosed, it may no longer be protected by federal and/or state privacy laws.
I understand that a determination will not be made until after this application has been received and reviewed by the Human Resources Dept. and the Superintendent.
I understand that this authorization will expire once my employment is terminated or as of date listed_____
I understand that I must submit a new form at the beginning of each school year.

Applicant's Signature: _____ Date: _____

Print Name:_____

PLAINFIELD PUBLIC SCHOOLS
EMPLOYEE STATEMENT (REQUESTING A 504 PLAN)

Section 2 (to be completed by employee)

Name: _____

Job Description
Describe in detail a description of your responsibilities with the Plainfield Public School District. The description must include, your duties, work hours, whether you are a 10 or 12 month employee, any other relevant information regarding your job.

_____

_____

_____

_____

_____

_____

_____

Requested Accommodation(s)
Explain in detail what specific accommodation(s) you are requesting, (which should include the following,) if the request is time sensitive, if the limitation(s) is interfering with the ability to perform your duties, how the accommodation(s) will assist you, the period of time the accommodation(s) will be needed, any other relevant information regarding this request. Also, include any assistive/adaptive equipment you will need to perform your duties.

_____

_____

_____

_____

_____

_____

_____

Section 3

PLAINFIELD PUBLIC SCHOOL'S
504 HEALTHCARE PROVIDER'S STATEMENT
To be completed by physician

Name:_____

Diagnosis of Medical Condition/Disability:_____

Surgical/ER visit dates (if applicable) - _____

Date(s) you treated the patient for condition in the past year. Please list dates of office visits._____

_____

_____

Will the patient need to have treatment visits in the upcoming 12 months? ☐**Yes** ☐**No**
If so, estimated number of visits:_____

_____

Please list any medications the employee takes daily and/or prn for this condition.

_____ _____ _____

_____ _____ _____

Will the condition cause exacerbations periodically, which may prevent the employee from performing his/her, job functions?
☐**Yes** ☐**No?**

Will the employee possibly be incapacitated for a single continuous period due to his/her medical condition? ☐**Yes** ☐**No**

If so, from date:_____ **to date:**_____

Will the patient need to work part-time? ☐**Yes** ☐**No: If yes how long:**_____

Will the patient need to work a reduced schedule? ☐**Yes** ☐**No**
If yes, explain reduced schedule:_____

Accommodations and/or assistive/adaptive equipment which are medically necessary for the employee to perform their duties. Please include a rationale for the requested accommodations.

_____

_____

_____

PLAINFIELD PUBLIC SCHOOL'S
504 HEALTHCARE PROVIDER'S STATEMENT
To be completed by Physician

Name of Attending Physician: _____
(please print)

Address: (Please stamp) _____

_____

_____

Signature: _____

Date: _____

Phone Number: _____