Hempstead School District
Office of Human Resources
185 Peninsula Blvd.
Hempstead, N.Y. 11550
(516) 434-4020 / 4021
www.hempsteadschools.org

Section 504 ADA Accommodation Request Form

For _____
Print Applicant's Name and, if applicable, Employee ID #

STATEMENT

Pursuant to Section 504 of the Rehabilitation Act of 1973, et al, the Hempstead Public Schools ("District"), will provide reasonable accommodations for (a) its qualified, disabled employees, provided the employees can perform the essential functions of their respective jobs, and (b) all other applicants that, by law, the District is required to accommodate. The information provided will be kept confidential and will be shared on a need to know basis only.

INSTRUCTIONS

The individual requesting an accommodation must file this form with the District's 504 Accommodation Officer / Office of Human Resources (at the address in the heading of this form), along with supporting medication documentation. The supporting medical documentation must include the following:

(1) diagnosis; (2) prognosis; (3) anticipated length of disability; (4) description of the requested accommodation; and (5) the original signature of the diagnosing physician.

The applicant may wish to submit the supporting medical documentation directly to:

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If hand-carried by the applicant, the applicant must deliver the medical documentation in a tamper-evident envelope.

Upon receipt of the fully executed application, the accommodation request will be reviewed in a timely manner by, or on behalf of, the 504 Accommodations Officer. The 504 Accommodation Officer will notify the applicant in writing of the determination. Employee-applicants are requested to continue to report to their respective location pending the 504 Officer's determination

1. Applicant's Information

Name _____, _____, _____
Last *First* *Middle Initial*

Home Address _____, _____
Residence Number and Street Name *Apt #, Floor, etc.*

_____ _____ _____
City *State* *Zip Code*

Home Phone _____ Mobile Phone _____

E-mail Address _____

IF APPLICANT IS A DISTRICT EMPLOYEE:

Work Location _____
School Name, Dept., etc

Title _____ Work Phone _____
Area Code and Number

Supervisor _____

Do you have a permanent disability? Yes ☐ No ☐

Were you approved for a previous reasonable accommodation? Yes ☐ No ☐

2. Medical Authorization

By execution of this application, I hereby authorize the use and/or disclosure of my health information to the 504 Officer. I further authorize the District's physician to communicate with my physician, care-taker, and/or the like in an effort to receive further information concerning my request for accommodation.

I understand that I have the right to revoke this authorization at any time by notifying the District's Associate Superintendent for Human Resources in writing of the revocation.

I understand that revocation is only effective after it has been received by the District's designee(s).

I understand that any use or disclosure made prior to revocation under this authorization will not be affected by a revocation.

I understand that after this information is disclosed, it may no longer be protected by federal and/or state privacy laws and the recipient may disclose it.

I understand that I am entitled to receive a copy of this authorization.

I understand that this authorization expires when (if I am a District employee) my employment is terminated, or as otherwise noted below:

_____ (expiration date: *end of school year*).

Applicant's Signature _____ **Date** _____

Printed Name of Applicant _____
First, Middle Initial, Last Name

3. Claimed Disability and Requested Accommodation

Please explain in detail the nature of applicant's claimed disability, and the accommodation requested. Such information must include any and all reasonable accommodations needed. Attached additional documents as necessary.

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Printed Name of Applicant

4. Additional Comments

Please use the remaining space if you wish to include comments regarding this application that have not been previously addressed.

Signature of Physician _____ *Date* _____

Provider's name and business address: _____

Type of Practice / Medical Specialty: _____

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