Sandra Montañez-Diodonet, Ed.D.
Superintendent of Schools

Miguel Frias
Director of Human Resources

Request for Reasonable Accommodation
(Y*ou must present a copy of your job description to your physician*)

This form must be completed by the individual requesting a reasonable accommodation and submitted to the Division of Human Resources. Information regarding requests for reasonable accommodations is confidential and will be shared only with appropriate personnel as necessary. Your cooperation is essential in order to ensure a productive, interactive process with the goal of finding an acceptable accommodation.

Also, please be advised that a Request for Reasonable Accommodation is temporarily and must be updated annually, if needed.

Once completed, please email documents to hrbenefits@passaicschools.org for review.

Employee to Complete:

Employee Name: _____

Job Title: _____

Work Schedule (days and times): _____

Work Site(s): _____

Physician to Complete:

Physician's Name: _____

Office Address: _____

_____

Telephone:_____

Facsimile:_____

Email: _____

Please note a medical note must be attached to this form to support your request.

Information Concerning Employee:

a. What is the nature of the medical condition?

b. Anticipated duration of condition:

c. What specific accommodation is the employee requesting?

d. What, if any, job functions are they having difficulty performing?

e. What limitation is interfering with the ability to perform their job duties?

f. What workplace accommodations would enable the Employee to perform the duty or duties otherwise impacted by their medical condition:

g. Next scheduled examination date (during which the Employee's need for an accommodation will be re-assessed):

Physician's Signature:_____ Date: _____

(See next page for medical authorization)

EMPLOYEE AUTHORIZATION TO RELEASE/DISCLOSE INFORMATION TO THE PASSAIC BOARD OF EDUCATION.

I,_____, authorize the Division of Human Resources and the Office of the Superintendent of the Passaic School District to speak with and disclose information and records to my doctor concerning the information contained herein, for purposes of seeking clarification of the information that has been provided. I similarly authorize my doctor, named above, to speak with and disclose information and records to the

_____.

This authorization shall expire on June 30, 2025.

Employee Signature:_____Date: _____