NYC Emergency Management

REASONABLE ACCOMMODATION REQUEST FORM

This form and all information must be kept confidential.

APPLICANT/EMPLOYEE INFORMATION	
Print Full Name	☐ Job Applicant ☐ Current Employee ☐ Other
Home or Work Address	**Phone Number**

EMPLOYEE INFORMATION (Complete this section if you are working at the agency even if you are currently on leave.)		
Civil Service Title	**Office Title**	
Office Telephone Number	**Division**	**Supervisor Name and Phone Number**
Location		

APPLICANT INFORMATION (Complete this section only if you are a job applicant)	
Position/Title Sought	**Division/Unit (if known)**
Location of Position (if known)	
Part(s) of employment process for which an accommodation is requested	
☐ **Job Application**	**Job Vacancy Notice Number (if known):**

☐ Interview	Interview Date:
☐ At Work	
☐ Other (please specify):	
Agency Contact Person (if known)	Phone Number

Basis of reasonable accommodation request:

- ☐ Disability
- ☐ Religion

  Describe your religious belief/practice/observances and identify the accommodations that you request:

  _____

  _____
- ☐ Status as Victim of Domestic Violence Sex Offenses or Stalking
- ☐ Pregnancy, childbirth or a related medical condition

Identify the situation which requires accommodation.

<u>Be specific.</u> (Attach additional sheets of paper, if necessary.)

_____

_____

_____

_____

Is the condition for which you are requesting an accommodation

☐ Permanent ☐ Temporary ☐ Unknown

If temporary, anticipated date accommodation(s) no longer needed:

Describe the nature of reasonable accommodation requested and how the accommodation will assist you to perform the essential functions of the position held or desired, or to enjoy the benefits and privileges of employment. Please be specific.
(Attach additional sheets and present supporting documentation as appropriate.)

_____

_____

If equipment is requested, please specify brand, model number and vendor, if known.

_____

_____

For Reasonable Accommodations based on Disability you may be required to provide verification by a health professional or a disability service provider (e.g. ACCESS-VR, NYS Commission for the Blind and Visually Impaired).

<u>This CONFIDENTIAL documentation should be provided</u>

<u>to the EEO Officer.</u>

Documentation <u>must:</u>

- ☑ **Be written on the official letterhead of the qualified health professional or health professional's organization.**
- ☑ **Identify the health professional's credentials. e.g., M.D., D.O.**
- ☑ **Be dated and signed by the health professional.**
- ☑ **Describe the severity of the disability and its limitations in detail as they currently exist and only in relationship to the job.**
- ☑ **State whether the duration of disability is permanent or temporary or unknown.**
- ☑ **If temporary, specify the date the disability is expected to no longer require accommodation.**
- ☑ **Indicate the extent to which the accommodation will permit you to perform the essential functions of the job or to enjoy the benefits and privileges of employment.**

I certify that I have read and understood the information provided in this request, and that it is true to the best of my knowledge, information and belief.

Date	**Requestor's Signature/Authorized Agent**

After completing the form please submit this document to the EEO Officer. **DO NOT WRITE IN THIS SECTION**
Name and Title of Supervisor:
Unit/Division:
Location:
Phone Number:
Date Request Received:

☐ **Supporting Documentation Included**	☐ **Supporting Documentation Not Included**	**Date:**
Signature		

Date Request Received by EEO Officer:
Date Supporting Documentation Received EEO Officer(If any):
Signature