

CORRECTION DEPARTMENT CITY OF NEW YORK

REQUEST FOR REASONABLE ACCOMMODATION

Form: RRA-1 Eff.: 02/23/23 Ref.: Dir. #2232R-B



SECTION I - TO BE COMPLETED BY APPLICANT / EMPLOYEE					
A) Applicant / En	ոployee's Data:				
Last Name:	First Name:	Rank/Title:	Shield/ID #:		
Address:	Postal Code:	Town/E	Borough:		
	Postal Code:	Teleph	one #:		
Email:					
	Please check of Job Applicant		mployee		
B) Applicant Information (complete this section only if you are applying for a job with the department or undergoing the selection process)					
Position/Title Applied for:					
Location of Position (if known):					
Part(s) of employment process for which an accommodation is requested (Check all that apply):					
Job Applica		:			
	tion interview Other.	(Write in de	escription)		
Department Con	tact Person (if known):	Telephone #	# :		
C) Complete this section only if current employee:					
Civil Service Title / Office Title :					
Work Telephone Number:					
Work Assignment Location:					
J					
D) Type of Accommodation Sought (check one):					
☐ Disability					
Religious					
Victim of: Domestic Violence / Sex Offenses / Stalking					
Pregnancy	y, Pregnancy Related Conditions				
E) Reasonable Accommodation Request: (Identify the situation which requires an accommodation. Be specific and attach additional sheets if necessary.)					
Is the condition for which you are requesting an accommodation? (Select one):					
Permanent					
Temporary. If temporary, anticipated date accommodation is no longer needed					
Unknown					



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REQUEST FOR REASONABLE ACCOMMODATION

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SECTION I - TO BE COMPLETED BY APPLICANT / EMPLOYEE (Continued)

E) Re	easonable Accommodation Request:			
perfo	ribe the nature of the reasonable accommodation requested and how the accommodation requested and how the accommodation requested, or to enjoy the benefits and hadditional sheets and present supporting documentation as appropriate).			
If the	need for an accommodation is not obvious, you may be required to provide documentation.			
	ation by a health professional or a disability service provider (e.g. ACCESS-VR, NYS Commission for the Blind and Visua modation must meet the following criteria:	Illy Impaired) for your reasonable		
a)	Documentation must provide diagnosis of mental or physical disability and include a recommendation for a specific ac	commodation.		
b)	The documentation must be written on the official letterhead of the qualified health professional or professional health	organization.		
c)	The health professional's credentials must be identified.			
d)	The documentation must be dated and signed by the health professional. Describe the limitations in detail as they cur only in relationship to the specific job, and state whether the disability is permanent or temporary.	rently exist and		
e)	If temporary, specify the date the disability is expected to no longer require accommodation.			
f)	Indicate the extent to which the accommodation will permit the employee to perform the essential functions of the job benefits and privileges of employment.	or enjoy the		
	Note: You are responsible for any expense incurred in providing medical documentation to the agency from your provider(s). If the agency determines that a second opinion is needed from a provider selected by the agency, the agency will be responsible for the expenses for additional information from that provider.			
	In addition, by executing this request, you grant the Equal Employment Opportunity Office permission care provider directly in the event that further details regarding your condition may be relevan accommodation.			
Appli	icant / Employee's Signature:	Date:		
DO NOT WRITE BELOW THIS LINE				

Please submit completed form and any supporting documentation to: DL - RARequest@doc.nyc.gov