Office of Human Resources
145 Spring Valley Road
Paramus, NJ 07652-5390

Carla Alvarez, Director
(201) 261-7800, ext. 3005
calvarez@paramusschools.org
Fax (201)576-9180

Employee Request for Reasonable Accommodation
Americans with Disabilities Act (ADA)

INSTRUCTIONS FOR EMPLOYEE:

Step 1: Fill the Employee section on the attached page. Sign and date where indicated.

Step 2: Take both forms (**"Employee" and "Interactive Process Certification and Questionnaire"**), **along with a copy of your job description supplied by the Human Resources Department**, to the appropriate medical provider. Ask the medical provider to examine the job description and fill out the Interactive Process Certification and Questionnaire.

Step 3: You, or your physician, should return the completed forms to the Human Resources Department (by personal delivery, mail, fax, or electronic transmission).

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Step 4: Paramus Public Schools - Human Resources Department will contact you for an appointment to begin the interactive process of evaluating your request.

NOTES TO EMPLOYEE:

Paramus Public Schools will make every effort to reasonably accommodate employees in accordance with the Americans with Disabilities Act of 1990 (ADA), as amended.

The ADA defines disability as a mental or physical impairment that substantially limits a major life activity, and generally requires accommodation for employees who are qualified to perform their essential job duties and have a disability or have a record of having a disability.
PLEASE NOTE ALL ACCOMODATION REQUESTS REQUIRE MEDICAL CERTIFICATIONS.

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EMPLOYEE

Printed Name: _____ Last 4 digits of SSN: _____

Job Title: _____ Location: _____

Home Address: _____

Best Contact Phone #: _____ Personal Email: _____

1. What if any, job function are you having difficulty performing?

2. How does your disability affect the essential functions of your job?

3. Do you have a suggestion on an accommodation? Yes ☐ No ☐
If yes, please describe how it will assist you:

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4. I am seeking an accommodation for the period _____ to _____.

☐ I have attached a completed Physician's Certification form.

☐ The Physician's Certification is being sent under separate cover.

☐ I have not yet seen my physician. My appointment is _____.

NOTE TO EMPLOYEE:
Paramus Public Schools' Human Resources staff may need to contact your healthcare provider directly.

By signing the **Authorization for the Use and Disclosure of Protected Health Information Form** on the next page, you give Paramus Public Schools' Human Resources staff authorization to contact your medical provider regarding medical information needed to process this request for ADA reasonable accommodation.

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Authorization for the Use and Disclosure of Protected Health Information

In connection with my request for accommodation from my employer under the American with Disabilities Act (ADA), I hereby authorize the use and disclosure of my protected health information as described below to the Paramus Board of Education's ("Board") Medical Inspector for the purpose of evaluating and substantiating my request for accommodations from my employer.

I, _____ hereby authorize,

Dr._____ to disclose, make

available, and furnish the following to the Paramus School District's physician, Dr. Michael Meese.

Contact Information:
Dr. Michael Meese
17 Elm Ave.
Hackensack, NJ 07601
Phone: (201) 968-0508
FAX: (201) 968-0509
Email: drmeese@optonline.net

Any and all information (including computer-generated information), documents, records, reports, notes, correspondence, patient charts, prescriptions, x-rays, and test results relating to the condition that led to my request for leave from employment, along with the approximate date of examination, treatment, consultation or admission to hospital that led to my request for sick leave from my employment and the accommodations that I am presently seeking from my employer.

I understand that I may revoke this authorization at any time by notifying the organization providing the information in writing with a copy of this written revocation to the Board. However, the revocation will not be valid if the Board has taken action in reliance on this authorization. Further, revoking this authorization may impact my ability to be granted accommodations.

_____ _____
Employee's Name (Please Print) Date

_____ _____
Employee Signature: Date

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INSTRUCTIONS FOR MEDICAL PROVIDER:

Review the duties and requirements on the employee's job description which is attached. If not attached please contact Paramus Public Schools Human Resources Department at 201-261-7800 Ext. 3002 or 3048 and ask for a copy of the applicable job description to be faxed to you.

Fully complete the **Interactive Process Certification and Questionnaire** beginning on the next page and return it to the employee or directly to Paramus Public Schools Human Resource Services Department at the location noted in Step 3.

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ADA – ACCOMODATION REQUEST
INTERACTIVE PROCESS CERTIFICATION AND QUESTIONNAIRE
[TO BE COMPLETED BY HEALTHCARE OR MEDICAL PROVIDER[1]]

To: Healthcare or Medical Provider
From: Paramus Public Schools' Human Resources Department

Please feel free to add attachments if you need more room to give your complete opinion. Thank you for your cooperation which will help Paramus Public Schools process this request.

PLEASE DO NOT TAKE INTO CONSIDERATION ANY AMELIORATIVE EFFECTS OF MITIGATING MEASURES; USE OF ASSISTIVE TECHNOLOGY, AUXILIARY AIDS OR SERVICES; REASONABLE ACCOMMODATIONS; OR LEARNED BEHAVIORAL OR ADAPTIVE NEUROLOGICAL MODIFICATIONS UNLESS ASKED TO PROVIDE SUCH INFORMATION. Mitigating measures include medications, medical supplies, equipment, or appliances, low-vision devices (excluding ordinary eyeglasses or contacts), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, insulin, mobility devices, and oxygen therapy equipment/supplies.

Employee's Name: _____

Employee's Job Title: _____

Medical Provider's printed name and address: _____

_____

_____

Medical Provider's Telephone Number: _____ Fax Number: _____

Medical Provider's Specialty: _____

[1] For purposes of this request, a healthcare or medical provider is defined as someone authorized to practice and provide services, and qualified to provide certification of physical or mental impairment, and who is performing within the scope of their practice as defined under applicable state law.

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ADA – ACCOMODATION REQUEST
INTERACTIVE PROCESS CERTIFICATION AND QUESTIONNAIRE

Please supply the information requested below, as fully as possible.

1. Does employee have an impairment/condition? Yes ☐ No ☐ Physical ☐ Mental ☐

2. If so, clearly identify the impairment/condition (You can attach additional pages):

3. How long do you expect the impairment to last?

4) In your opinion, does the impairment substantially limit any major life activity?

   Yes ☐ No ☐

   If yes, state the major life activities that are limited:

5) For each major life activity that is limited by the impairment, describe how the employee is restricted as to the condition, manner, or duration under which that activity can be performed, as compared to the way an average person in the general population can perform that activity?

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ADA – ACCOMODATION REQUEST
INTERACTIVE PROCESS CERTIFICATION AND QUESTIONNAIRE

6) Did the employee provide you with a copy of the applicable job description?

Yes ☐ No ☐

7) Did the employee provide you with a recitation of the essential functions of their job?

Yes ☐ No ◯

If yes, please provide the information given to you by the employee as to the essential functions of their job.

8) Is employee able to perform all essential job functions and physical requirements?

Yes ☐ No ☐

If not, specify any essential job functions/requirements that cannot be performed, and explain why not.

9) Describe any reasonable accommodations you recommend to enable the employee to perform their essential job duties.

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ADA – ACCOMODATION REQUEST
INTERACTIVE PROCESS CERTIFICATION AND QUESTIONNAIRE

10) In your opinion, would performing any of employee's essential job duties pose a direct health or safety threat to the employee, co-workers, students, members of the general public, etc.?

Yes ☐ No ☐

If yes, please state:

a) Which job duties would result in such a threat?

b) What is the specific threat?

c) Are there any reasonable accommodations that would eliminate the threat, or reduce it to an acceptable level?

Yes ☐ No ☐

If yes, please describe the accommodations:

12. Next treatment/examination date of Employee. _____

_____ _____
Medical Provider's Signature and Title: Date