IRVINGTON TOWNSHIP
ADA/NJLAD EMPLOYEE ACCOMMODATION REQUEST

The Irvington Township pursuant to Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, ADA/New Freedom of Initiatives, Title VII of the Civil Rights Act of 1964 amended by the Equal Opportunity Commission and Title I of the ADA will, in good faith, provide reasonable accommodations for its qualified employees. The Township may require additional information in order to consider when to provide a reasonable accommodation and when to be interactive with certain parties in an effort to determine what, if any, accommodations should be provided. The Township will regard the dissemination of information in order to make determination regarding accommodations on a "need to know basis". In addition, the Township will act in a timely manner on such requests for accommodation. It should be noted information submitted is kept in confidence.

INSTRUCTIONS:

Township employees requesting accommodation as a result of a medical condition must file this ADA/NJLAD 504 Accommodation Request Form and submit supporting medical documentation to the Office of the Business Administrator for review and consideration. Thereafter, the Business Administrator will convene the 504 Committee to address this request.

Please note that Section 1, entitled "Applicant's Information," must be signed by the applicant's Supervisor. The applicant must submit the request, supported with the necessary medical documentation that includes: diagnosis, prognosis, time period in which the applicant seeks an accommodation, and a detailed description of the accommodation being requested.[1]

To protect the applicant's privacy rights, the 504 Committee respectfully requests that the supporting medical documentation be submitted directly to the Office of the Business Administrator, Attention Musa A. Malik, 1 Civic Square, Irvington, New Jersey 07111. Upon receipt and acknowledgement of the fully executed request, the 504 Committee will review the request in an effort to make a determination as to whether the requested accommodation is "reasonable" and "feasible". Upon such determination, the 504 Committee will notify all interested parties of its determination in a timely manner. Please complete the attached application. Print clearly where applicable.

After submitting this form and supporting medical documentation, the applicant must provide, in writing, his/her availability for a meeting to discuss this request to the Business Administrator. At the time of this meeting, the applicant must bring a union or legal representative or provide, in writing, why he/she has elected to represent him/herself.

[1] The request for documents means ALL documents related to this request. A one (1) page "prescription" or "return to work" form is insufficient. You MUST produce all underlying medical documentation related to your request.

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SECTION 1:

Name: _____ **Date:** _____

Address: _____ **Phone:** _____

City: _____ **Zip Code:** _____

Department/School: _____ **Title:** _____

Location: _____ **Phone:** _____

Applicant's Signature: _____

Supervisor's Signature: _____

Supervisor's Name: _____ **Phone:** _____

Date: _____

SECTION 2:

MEDICAL AUTHORIZATION/WAIVER

By way of execution of this Confirmation of Accommodation Request Form and the Medical Release Form (attached to this application), I hereby authorize the use/or disclosure of my health information to the members of the Irvington Township ADA/NJLAD 504 Accommodation Committee and grant this waiver for a period of ninety (90) days from the below date of execution. I understand that I have the right to revoke this authorization at any time by notifying the Township, in writing, of the revocation to the attention of Musa A. Malik, Business Administrator, Irvington Township, 1 Civic Square, Irvington, New Jersey, 07111.

I understand that revocation is only effective after it is received and recorded by the Township. 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 my employment is terminated, unless otherwise noted here_____ (expiration date).

Applicant's Signature: _____ **Date:** _____

Print Name: _____

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SECTION 3:

Job Description – describe, in detail, the nature and responsibilities of your position with the Irvington Township. The description should include, but not be limited to, work hours and duties performed.

SECTION 4:

Requested Accommodation - In detail, explain the accommodation requested. Such information must include: any and all reasonable accommodations needed; the reasonable time period for the required accommodation(s). (Attach any additional information).

Do Not Write Below This Line, Proceed to Page 4 and Complete the Medical Release

SECTION 5: ADA/NJLAD 504 COMMITTEE ONLY

Date Request Received by Office of the Business Administrator: _____

Name and Signature of receiving party: _____ _____
Print **Signature**

**Applicants are to submit this application and receive an executed copy of Section 5 of the application within two (2) working days.*

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MEDICAL RELEASE FORM

Date: _____

I _____ hereby authorize _____
Employee Name Patient's Physician or Medical Facility
to release the following information.

( ) All Medical Records or ( ) _____

I understand this information is confidential and, in accordance with HIPPA laws, is to be held as such by the recipient of this information.

This authorization is valid for ninety (90) days and may be revoked at any time in writing prior to the expiration date.

_____ _____
Patient's Signature Date

SS#: _____

Date of Birth: _____

IRVINGTON TOWNSHIP
EMPLOYEE ACCIDENT INJURY REPORT

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient/Employee Name: _____

Patient/Employee DOB: _____

Patient/Employee SSN: _____

I hereby request and authorize the release of my medical information by the following provider:

Name of Provider: _____

Address: _____

Phone No.: _____

To the following:

Irvington Township

Office of the Business Administrator

1 Civic Square

Irvington, New Jersey 07111

I understand this information is confidential and, in accordance with HIPPA Law, is to be held as such by the recipient of this information.

This authorization is valid for ninety (90) days from the date of this release and may be revoked at any time, in writing, prior to the expiration date

Patient/Employee Signature: _____ Date: _____