

SADDLE BROOK SCHOOL DISTRICT

355 Mayhill Street, Saddle Brook, New Jersey 07663 Phone 201.843.1142 Fax 201.843.0216

504 Employee Request:

The Saddle Brook Public School District 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 District 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 District will regard the dissemination of information in order to make determination regarding accommodations on a "need to know basis". In addition, the District will act in a timely manner on such requests for accommodation. It should be noted information submitted is kept in confidence.

Instructions:

The Saddle Brook Public School District employee requesting accommodation(s) as a result of a medical condition must file the Section 504 Accommodation Request Form and submit this with the supporting documentation to the Human Resources office for review and consideration. Please note that Section I, 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 accommodations, and a detailed description of the accommodation being requested.

To protect the applicant's privacy rights, please send the application and supporting documents directly to Mrs. Danielle Shanley, Superintendent of Schools; Saddle Brook Public District; 355 Mayhill Street; Saddle Brook, NJ 07663. The applicant may also scan and email the completed 504 Application to Danielle Shanley at dshanley@sbpsnj.org. Upon receipt and acknowledgement of the completed request, the application will be reviewed as to whether the request is "reasonable" and "feasible." Please be advised that the District reserves the right to consult the school physician in order to make a more informed decision. Upon such determination, we will notify all interested parties of its determination in a timely manner. Please complete the attached application, print it, sign where indicated, and return it along with all documentation to the above address.

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Employee Disability Accommodation Request

Print Employee Name (Last, First, Middle)	Social Security Number	
Department	Assignment/Title	
Location		
Please describe the limitation you are addressing:		
. How does your disability affect the essential funct	ions of your job?	
. Do you have a suggestion on an accommodation? If yes, please describe:		
. Please describe how you will benefit from it:		
Employee comments:		
 ☐ I have attached a completed Physician's Certifi ☐ The Physician's Certification is being sent under I have not yet seen my physician. My appoint 	er separate cover.	
If you have any questions regarding my request ple	ase, contact me at: ()	
Employee Signature	/ / / yyyy	

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Employee Authorization for Release of Records for Disability Accommodation Request

Print Employee Name (Last, First, Middle)		
Print Physician / Practitioner Name		
I, to exchange any of my Protected Health Informat medication, psychological and/or sociological inform "Board") for the purpose of disability accommodation release of a copy of my PHI, or a summary or narrative of	tion ("PHI"), including, bunation, to the Parsippany-Torrequest evaluation. By sig	Troy Hills Public Schools (the ming this form, I authorize the
Any information shared will be treated in a professional purpose of disability accommodation request evaluation employee's confidential file. The effect of granting this subject to re-disclosure by the recipient, in which can Portability and Accountability Act of 1996 ("HIPAA")	on. Information received by authorization may be that the	the Board will be placed in the ne PHI used or disclosed may be
The Board, its programs, services, employees, officers responsibility for disclosure of my PHI to the extent inc		hereby released from any legal
The authorization is given voluntarily. The Board will giving of this authorization.	not condition the grant of d	isability accommodation on the
I understand that I may revoke this authorization at Board. I understand that revocation of this authorization this authorization before written notice of the redisclosed in reliance on this authorization, revoking it	ion will not affect any action evocation was received. If	n taken by the Board in reliance f information has already been
This authorization expires one year form the date of the	e employee signature.	
I have had a full opportunity to read and consider th signing this form, I am confirming my authorization of form.		
Employee Signature	mm c	dd yyyy
Employee Supervisor Signature	//	ld yyyy
	lle Shanley, Superintendent ok Public Schools	

355 Mayhill Street Saddle Brook, NJ 07663

Phone: 201-843-1142

(Do not fax forms, scan and send to dshanley@sbpsnj.org)

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Physician Certification for Employee Disability Accommodation

Print Employee Name (Last, First, Middle)	Examination Date
Drint Dhysisian Name	Novy Ionory Licones Nilan
Print Physician Name	New Jersey License Number
$\ \square$ I certify that the above named patient	is permanently / temporarily disabled and (circle one)
may / may not require an accommoda (circle one)	
Please Check and Complete One of the Fo	ollowing Three Options
	/ / and certify that
the patient has the following permanent	t / temporary functional limitation(s):
☐ I examined the above named patient on.	/ and I am unable to
to make a determination without furthe	mm dd yyyy er examination. The patient is scheduled for a
follow-up examination on / / dd /	withwith
	mm dd yyyy and have not found ay return to regular duty without restrictions on:
Physician Comments:	
Physician Street Address	Suite #
City	State Zip
	- 10 10 11 10 11 11 11 11 11 11 11 11 11
Phone Number	Medical Specialty
Physician's Signature	