City of New Haven
Dept. of Services for Persons with Disabilities
165 Church Street
New Haven, CT 06510
(203) 946-7651
Fax (203) 946-6934
TTY (203) 946-8582

New Haven Public Schools
Human Resources & Labor Relations
54 Meadow Street
New Haven, CT 06519
475-220-1540

ADA ACCOMMODATION REQUEST FORM

NAME:_____ DATE: _____

ADDRESS: _____

PHONE:_____ EMAIL: _____

WHERE DO YOU WANT CORRESPONDENCE SENT? WORK ☐ HOME ☐

JOB TITLE: _____

SUPERVISOR/DEPT. HEAD: _____

What you need to know about the accommodation process:

1. All information provided to the Department of Services for Persons with Disabilities is confidential and will only be used to provide an appropriate accommodation to employees with disabilities whom have requested an accommodation.
2. Most employees who request an accommodation will be asked to submit medical documentation to verify that they are a person with a disability as defined in the ADA.
3. All information and documentation submitted from a health care provider must be written within the previous twelve (12) months to the date of application to insure that the accommodation meets the current needs of the employee.
4. Any health care provider used to support this application must be willing and able to speak knowledgeably about the disability and willing to work with our staff in determining the best accommodation for the employee.

A. Questions to help determine whether you have a disability.		
For reasonable accommodation under the ADA, an employee has a disability if he or she has an impairment that substantially limits one or more major life activities or a record of such an impairment. The following questions may help determine whether an employee has a disability:		
Do you have a physical or mental impairment?	Yes ☐	No ☐
If *yes*, what is the impairment?		
Is the impairment long-term or permanent?	Yes ☐	No ☐
If *not* permanent, how long will the impairment likely last?		

Answer the following questions based on what limitations you have when your condition is in an active state and what limitations you would have if no mitigating measures were used. Mitigating measures include things such as medication, medical supplies, equipment, hearing aids, mobility devices, the use of assistive technology, reasonable accommodations or auxiliary aids or services, prosthetics, and learned behavioral or adaptive neurological modifications. Mitigating measures do not include ordinary eyeglasses or contact lenses.

Does the impairment substantially limit a major life activity?	Yes ☐	No ☐

If *yes*, what major life activity(s) is/are affected?

☐ Caring For Self	☐ Walking	☐ Hearing	☐ Lifting	☐ Other: (describe)
☐ Interacting With Others	☐ Standing	☐ Seeing	☐ Sleeping	
☐ Performing Manual Tasks	☐ Reaching	☐ Speaking	☐ Concentrating	
☐ Breathing	☐ Thinking	☐ Learning	☐ Reproduction	
☐ Working	☐ Toileting	☐ Sitting	☐ Eating	
☐ Communicating	☐ Reading	☐ Bending		

Does the impairment substantially limit the operation of a major bodily function?	Yes ☐	No ☐

If yes, what bodily function is affected?

☐ Immune	☐ Hemic	☐ Circulatory	☐ Other: (describe)
☐ Normal Cell Growth	☐ Special Sense Organs and Skin	☐ Endocrine	
☐ Digestive	☐ Lymphatic	☐ Reproductive	
☐ Bowel	☐ Neurological	☐ Musculoskeletal	
☐ Bladder	☐ Brain	☐ Special Sense	
☐ Genitourinary	☐ Respiratory	☐ Cardiovascular	

B. Questions to help determine whether an accommodation is needed.

An employee with a disability is entitled to an accommodation only when the accommodation is needed because of the disability. The following questions may help determine whether the requested accommodation is needed because of the disability:

What limitation(s) is interfering with job performance?

Will you need to be absent due to the condition? If yes, how often will you need to be absent?

What job function(s) are you having trouble performing because of the limitation(s)?

How does your limitation(s) interfere with your ability to perform the job function(s)?

C. Questions to help determine effective accommodation options.

The following questions may help determine effective accommodations:

Do you have any suggestions regarding possible accommodations to perform the duties of your position?

If so, what are they?

D. Additional Relevant Information.

PLEASE PROVIDE THE NAME, PHONE NUMBER AND FAX OF YOUR CURRENT TREATING HEALTH CARE PROVIDER THAT CAN SPEAK TO YOUR CURRENT LIMITATIONS. BE SURE TO CONTACT YOUR HEALTH CARE PROVIDER TO NOTIFY THEM THAT THIS DEPARTMENT WILL BE CONTACTING THEM. ALL MEDICAL INFORMATION PROVIDED TO THE DEPARTMENT OF SERVICES FOR PERSONS WITH DISABILITIES IS STRICTLY CONFIDENTIAL AND WILL ONLY BE USED IN EVALUATING THIS ACCOMMODATION REQUEST.

HEALTH CARE PROVIDER'S NAME: _____

ADDRESS: _____

PHONE: _____

FAX: _____

I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS REQUEST IS A TRUE AND ACCURATE.

_____ DATE: _____

EMPLOYEE'S SIGNATURE

IF YOU ARE AN EMPLOYEE THAT WORKS IN A NEW HAVEN PUBLIC SCHOOLS FACILITY OR ADMINISTRATION DIRECT ALL QUESTIONS AND RETURN THIS FORM TO:

TARYN BONNER
(475) 220-1549
HUMAN RESOURCES & LABOR
RELATIONS54 MEADOW STREET
NEW HAVEN, CT 06519

IF YOU ARE AN EMPLOYEE THAT WORKS FOR ANY CITY DEPARTMENT THAT IS NOT PART OF THE BOARD OF EDUCATION, DIRECT ALL QUESTIONS AND RETURN THIS FORM TO:

GRETCHEN KNAUFF
(203) 946-7651
FAX (203) 946-6934
TTY (203) 946-8582
DEPARTMENT OF SERVICES FOR PERSONS WITH
DISABILITIES165 CHURCH STREET
NEW HAVEN, CT 06510