



Hempstead School District
Office of Human Resources
185 Peninsula Blvd.
Hempstead, N.Y. 11550
(516) 434-4020 / 4021
www.hempsteadschools.org

Section 504 ADA Accommodation Request Form

For _____
Print Applicant's Name and, if applicable, Employee ID #

STATEMENT

Pursuant to Section 504 of the Rehabilitation Act of 1973, et al, the Hempstead Public Schools ("District"). will provide reasonable accommodations for (a) its qualified, disabled employees, provided the employees can perform the essential functions of their respective jobs, and (b) all other applicants that, by law, the District is required to accommodate. The information provided will be kept confidential and will be shared on a need to know basis only.

INSTRUCTIONS

The individual requesting an accommodation must file this form with the District's 504 Accommodation Officer / Office of Human Resources (at the address in the heading of this form), along with supporting medication documentation. The supporting medical documentation must include the following:

(1) diagnosis; (2) prognosis; (3) anticipated length of disability; (4) description of the requested accommodation; and (5) the original signature of the diagnosing physician.

The applicant may wish to submit the supporting medical documentation directly to:

Hempstead School District
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If hand-carried by the applicant, the applicant must deliver the medical documentation in a tamper-evident envelope.

Upon receipt of the fully executed application, the accommodation request will be reviewed in a timely manner by, or on behalf of, the 504 Accommodations Officer. The 504 Accommodation Officer will notify the applicant in writing of the determination. Employee-applicants are requested to continue to report to their respective location pending the 504 Officer's determination

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1. Applicant's Information

Name _____
Last First Middle Initial

Home Address _____
Residence Number and Street Name Apt #, Floor, etc.

Home Phone _____ *City* Mobile Phone _____ *State Zip Code*

E-mail Address _____

IF APPLICANT IS A DISTRICT EMPLOYEE:

Work Location _____
School Name, Dept., etc.

Title _____ Work Phone _____
Area Code and Number

Supervisor _____

Do you have a permanent disability? Yes No

Were you approved for a previous reasonable accommodation? Yes No

2. Medical Authorization

By execution of this application, I hereby authorize the use and/or disclosure of my health information to the 504 Officer. I further authorize the District's physician to communicate with my physician, care-taker, and/or the like in an effort to receive further information concerning my request for accommodation.

I understand that I have the right to revoke this authorization at any time by notifying the District's Associate Superintendent for Human Resources in writing of the revocation.

I understand that revocation is only effective after it has been received by the District's designee(s).

I understand that any use or disclosure made prior to revocation under this authorization will not be affected by a revocation.

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 (if I am a District employee) my employment is terminated, or as otherwise noted below:

_____ (expiration date: *end of school year*).

Applicant's Signature _____ Date _____

Printed Name of Applicant _____
First, Middle Initial, Last Name

Lined writing area for notes or details.

Signature of Physician _____ *Date* _____

Provider's name and business address: _____

Type of Practice / Medical Specialty: _____

Telephone: () _____ *Fax:* () _____