Farmingdale State College
STATE UNIVERSITY OF NEW YORK

FORM A

Application to Request Reasonable Accommodation of a Disability

Application for reasonable accommodation may be made to the supervisor or directly to the Responsible College Official as set forth in the College's Policy & Procedure on Reasonable Accommodations for State Employees. If the request is made to the supervisor, the supervisor must forward the request to the Responsible College Official. **All confidential information received by department personnel pertaining to your request shall be handled as such.** All medical information is confidential and maintained separately from personnel records.

The following section is to be completed by employee and returned to supervisor or Responsible College Official:

Name	Title	Supervisor
Department	Work Location	Telephone Number(s)
E-mail address:	Preferred method of communication:	

I am requesting the following reasonable accommodation(s):
It is necessary for me to have this accommodation for the following reason(s):

Employee Signature:	Date:

The employee should retain a copy of Form A. The original is filed by the Responsible College Official.

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FORM B

Notification of Need for Supplemental Information/Medical Documentation

Section 1 -To be completed by the Responsible College Official:

Name of Employee: _____

We are continuing to assess your request. To make a determination, we need the following additional information (check all that apply):

☐ Medical Documentation

☐ Other

☐ We require no additional information from you at this time

Please inform your medical care provider of your application for an accommodation and have your medical care provider send us medical documentation, indicating the limitations that your disability would place on your job performance. We have enclosed a copy of the duties description for your title and/or a list of the essential functions of your position for medical care provider's reference. Utilizing such information, please submit medical documentation from your provider answering all questions listed in section 2 of this form. This documentation should be dated and signed and on your medical provider's letterhead.

Information should be sent by the following date: _____

The requested information must be provided to the Responsible College Official.

All medical information pertaining to Reasonable Accommodation must be kept confidential by the College.

The College's review process will include an evaluation of all relevant information. This may include an interview with you and/or your supervisor. After completion of the review, you will be informed in writing by the Responsible College Official regarding the decision. We anticipate that the decision will be made by (date): _____. *Note that this date is based on requested medical documentation being received by the date listed above (if medical documentation is required). If the documentation is not received by this date, the decision may be delayed accordingly.*

If you have any questions, please contact Responsible College Official.

Section 2 -To be addressed by medical provider:

On letterhead, please address the following questions to assist the employer in determining whether this employee has a disability and, if so, whether or not there is an accommodation that would enable the individual to perform the essential functions of their job in a reasonable manner, or to enjoy equal benefits and privileges of employment.

- Does the employee have a physical or mental impairment and, if yes, please provided diagnosis and describe the nature and severity? (Yes/No):
- Is this impairment (expected duration) temporary/permanent/episodic/in remission?
- If this impairment is temporary, how long will the impairment likely last? If this impairment is episodic or in remission, please explain:
- Does this impairment substantially affect one or more major life activities or functions of this employee? (Yes/No)
- If yes, please specifically list the major life activities and describe how each is affected:
- Please describe the functional limitation(s) of this employee caused by condition(s) or impairment(s) described above and the extent that the impairment limits the employee's ability to perform those activities:
- Please describe how the limitation(s) of this employee identified above, affects their ability to perform the job duties of their position:
- Please describe any recommended accommodation(s) that may enable this employee to perform his/her job duties or essential functions and explain the relationship of the accommodation to the functional limitation.

The employee should retain a copy of any submitted medical documentation. The original is filed by Responsible College Official.