Long Beach Public School District

Workplace Accommodation Request Form

Return this form to the Office of Human Resources with any additional supporting documentation.

235 Lido Boulevard, Lido Beach New York 11561♦Fax: 516-897-2115♦Phone: 516-897-2095

*** Completed by Employee ****

Employee: _____ **Date of Request:** _____/____/_____

Title: _____ **Location:** _____

Condition/limitation: _____

How does this condition/limitation affect your ability to perform the essential functions of your job?

_____

_____

_____

_____

Workplace accommodation(s) requested: _____

_____

_____

_____

_____

_____

*** Completed by Employee ***

Identify the names and addresses of physicians, therapists, psychologists, or other health care providers who have information or documentation concerning your disability, illness, condition, or disease or your need for a reasonable accommodation:

_____

_____

_____

_____

Should Long Beach Public Schools require further supporting medical documentation, I hereby authorize the above-listed health care providers and any others who have treated me to release to Long Beach Public Schools information concerning the disability disclosed herein and provide any opinions to them concerning my ability to perform essential job-related functions with or without reasonable accommodations.

I certify that the foregoing statements are complete, accurate, and true to the best of my knowledge, and I understand that Long Beach Public Schools may require me to undergo testing or evaluation by medical personnel retained by Long Beach Public Schools for the purpose of establishing the existence and extent of my disability to perform essential job-related functions with or without reasonable accommodations.

Employee's Signature: _____ **Date:** _____

*** Completed by the District Personnel***

◇Approved ◇ Not Approved ◇ Approved with modifications: _____

Signature: _____ **Date:** _____/_____/_____

Staff Notified on: _____/_____/_____