



# REQUEST FOR REASONABLE ACCOMMODATION & /or Leave Request - CONFIDENTIAL

Please complete the appropriate section of this checklist. The first section pertains to Americans with Disabilities Act (ADA) accommodation requests. The second section pertains to non-ADA Leave Requests. These forms should be returned to

## Northern Region Educational Services Commission Human Resources Department

SECTION 1: TO BE COMPLETED BY EMPLOYEE	
NAME OF EMPLOYEE: _____	JOB TITLE: _____
LOCATION: _____	TELEPHONE NUMBER: _____
PRINCIPAL / SUPERVISOR: _____	EMAIL: _____
<p>PLEASE NOTE ALL ACCOMMODATION REQUESTS REQUIRE MEDICAL CERTIFICATIONS</p> <p>When an employee’s disability or need for accommodation is not apparent or known to Northern Region Educational Services Commission, a certification from a health care provider verifying that an accommodation is necessary.</p> <p>____ I am seeking accommodations under the ADA because I am at high risk for contracting the COVID-19 virus under the CDC’s pandemic guidelines. <a href="https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-increased-risk.html">https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-increased-risk.html</a></p> <p>____ I am seeking accommodations under the ADA for non-COVID-19 related reasons. <a href="https://adata.org/factsheet/reasonable-accommodations-workplace">https://adata.org/factsheet/reasonable-accommodations-workplace</a></p> <p>1. What if any, job function are you having difficulty performing? _____</p> <p>2. How does your disability affect the essential functions of your job? _____</p> <p>Do you have a suggestion on an accommodation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe how it will assist you: _____</p> <p>3. I am seeking an accommodation for the period _____ to _____.</p> <p><input type="checkbox"/> I have attached a completed Physician’s Certification form.  <input type="checkbox"/> The Physician’s Certification is being sent under separate cover.  <input type="checkbox"/> I have not yet seen my physician. My appointment is _____.</p>	

Is the condition for which you are requesting an accommodation?

Permanent

Temporary - If temporary, anticipated date accommodation(s) no longer needed: \_\_\_\_\_

Unknown

**SECTION 2: LEAVE REQUEST - [COVID-19 Related](#)**

\_\_\_\_ I am seeking a leave for my own health condition including advisement by my healthcare provider or pursuant to a federal, state, or local public health authority order to quarantine or I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

Complete and submit the following form.

<https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-380-E.pdf>

\_\_\_\_ I am seeking a leave due to childcare needs during the COVID-19 pandemic. I am seeking the following schedule for childcare purposes:

\_\_\_\_\_

\_\_\_\_ I am seeking a leave to care for a covered family member with a serious health condition.

Relationship of family member to you: \_\_\_\_\_

Complete and submit the following form.

<https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-380-F.pdf>

\_\_\_\_ I am seeking a leave to care for a loved one who is in coronavirus quarantine, is coronavirus positive or symptomatic.

Complete and submit the following form.

<https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/WH-380-F.pdf>

\_\_\_\_ I am seeking a leave to self-quarantine for 14 days commencing \_\_\_\_\_ through \_\_\_\_\_ due to travel outside the State of New Jersey or other reasons NOT certified by healthcare providers or public health authorities.

I am seeking a leave for the period \_\_\_\_\_ to \_\_\_\_\_.

If intermittent or reduced-leave schedule is being requested, please explain why it is needed and the proposed leave schedule:

\_\_\_\_\_

I certify that the above information is true and correct to the best of my knowledge:

Employee Signature \_\_\_\_\_

Date: \_\_\_\_\_

Determination of eligibility for leave, and/or additional documentation or clarification of documentation, may be required prior to making a final leave determination.

**FOR EMPLOYER USE ONLY**

Documentation Received \_\_\_\_\_  
Date

Accommodation Approved (See separate Approval Form) \_\_\_\_\_  
Date

Accommodation Denied (See separate Denial Form) \_\_\_\_\_  
Date

Leave Approved for the Period \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date