FORM#504-1E

WAYNE TOWNSHIP PUBLIC SCHOOLS

Employee Disability Accommodation Request

(To Be Completed by Employee)

Employee Name: (last, first middle)	(Please print)		
Date of Birth:		Social Security #:	
Address:			
Telephone Number:		Department:	
		Assignment / Title:	

Facility:

❒ APT ❒ AWMS ❒ ECC ❒ FAL ❒ GWMS ❒ JFK ❒ LAF ❒ PACK ❒ PL ❒ Transportation
❒ RC ❒ RYER ❒ SCMS ❒ TD ❒ WHHS ❒ WVHS ❒ Central Office ❒ Other______________

1. Please describe the limitation you are addressing:

____

____

2. How does your disability affect the essential functions of your job?

____

____

3. Do you have any suggestions for accommodation? ❒ Yes ❒ No If yes, please describe:

____

____

4. Please describe how you will benefit accommodation:

____

____

Additional comments: ____

I have attached a completed Physician's Certification form.[1]

The Physician's Certification is being sent under a separate cover.

I have not yet seen my treating physician. My appointment is ______/______/_________.

If you have any questions regarding my request, please contact me at: ______________________________

Employee Signature: ______________________________ Date: ____________________

[1] Approval of accommodations may require documentation from a specialist physician. Please attach any relevant documentation or additional information which you believe may be of assistance in the accommodation review process.

FORM#504-2E

WAYNE TOWNSHIP PUBLIC SCHOOLS

Employee Authorization for Release of Records for Disability Accommodation Request

(To Be Completed by Employee)

Employee Name: (last, first middle)	(Please print)	DOB:	
Name of Physician / Practice:	(Please print)		

I, (name of employee)______________________________________, hereby authorize the above-listed physician/ practitioner to exchange any of my Protected Health Information ("PHI"), including, but not limited to, confidential medical, psychological and / or sociological information, to the Wayne Township Public Schools (the "Board") for the purpose of disability accommodation request evaluation. By signing this form, I authorize the release of a copy of my PHI, or a summary or narrative of my protected health information to the Board.

Any information shared will be treated in a professional and confidential manner and will be used for the exclusive purpose of disability accommodation request evaluation. Information received by the Board will be placed in the employee's confidential file. The effect of granting this authorization may be that the PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The Board, its programs, services, employees, officers, agents and / or assigns are hereby released from any legal responsibility or liability for disclosure of my PHI to the extent indicated and authorized.

This authorization is given voluntarily. The Board will not condition the grant of a disability accommodation on the giving of this authorization.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Board. I understand that revocation of this authorization will not affect any action taken by the Board in reliance on this authorization before written notice of revocation was received. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.

This authorization expires one year from the date of the employee signature.

I have had a full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and / or disclosure of my PHI, as described in this form.

Employee Signature: ___________________________________ Date: ______________________

Please send the requested information to:
Attn: 504 Committee Building Chair

____
(Staff Member Name)

____
(Staff Location)

____
(Address)
(To be filled in by Building 504 Committee Chair)

Rev. 11/2022

FORM#504-3E

WAYNE TOWNSHIP PUBLIC SCHOOLS

Physician Certification for Employee Disability Accommodation

(To Be Completed by Healthcare Provider)

		Date of Examination:	
Patient Name: (last, first middle)	(Please print)		
Patient's Date of Birth:			
Medical Diagnosis(es):			

Physician's Name:	(Please print)
Medical Specialty:	
New Jersey License Number:	

❑ I certify that the above named patient is (circle one) permanently / temporarily disabled and (circle one) may / may not require accommodation(s).

Please Check and Complete One of the Following Three Options:

❑ I examined the above-named patient on ________________________ and certify that the patient has the following (circle one) permanent / *temporary functional limitation(s):

*If limitations are temporary, please indicate estimated period of time: ________________________________

____

____

____

____

❑ I examined the above-named patient on _________________ and I am unable to make a determination without further examination. The patient is scheduled for a follow-up examination on _________________ with (Name of Physician / Specialty) ____

❑ I examined the above-named patient on _________________ and I have not found any limitations at this time. This patient may return to regular duty without restrictions on ____________________.

Physician Comment: ____

____

____

Signature of Physician: ____________________________________

Date________________ Telephone:___________________________

(Physician's Stamp with Address)

Attach any relevant documentation, reports or additional information which you believe may be pertinent to the accommodation review process.