BAYONNE BOARD OF EDUCATION
ADMINISTRATION BUILDING
669 Avenue A
Bayonne, NJ 07002

Kenneth Kopacz
ASSISTANT SUPERINTENDENT

Tel: (201)-858-5847
Fax: (201)-339-7431

FORM C

Request for Reasonable Accommodation

(*you must present a copy of your job description to your physician*)

Employee to Complete:

Employee Name: ______________________________

Job Title: ______________________________

Work Schedule (days and times): ______________________________

Work Site(s): ______________________________

Physician to Complete:

Physician's Name: ______________________________

Office Address: ______________________________

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Telephone: ______________________________

Facsimile: ______________________________

Email: ______________________________

Information Concerning Employee:

a. Nature of medical condition:

b. Anticipated duration of condition:

c. How the condition impacts the Employee's activities of daily living (i.e., walking, thinking, breathing, focusing):

d. How the condition impacts the Employee's ability to perform a duty or duties set forth in the Employee's job description (attached):

e. Whether the Employee requires one or more workplace accommodations to perform any duty or duties listed in his/her job description;

f. What workplace accommodations would enable the Employee to perform the duty or duties otherwise impacted by the medical condition:

g. How each identified workplace accommodation will enable the Employee to perform the duty or duties impacted by the medical condition:

h. Next scheduled examination date (during which the Employee's need for an accommodation will be re-assessed):

Physician's Signature: ___________________________________ **Date:** __________________

(see next page for medical authorization)

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EMPLOYEE AUTHORIZATION TO RELEASE/DISCLOSE INFORMATION TO THE BAYONNE BOARD OF EDUCATION.

I, ______________________________, authorize the Employee Health Department and the Office of the Superintendent of the Bayonne School District to speak with and disclose information and records to my doctor concerning the information contained herein, for purposes of seeking clarification of the information that has been provided. I similarly authorize my doctor, named above, to speak with and disclose information and records to the ______________________________.

This authorization shall expire on June 30, 2021.