REQUEST FOR REASONABLE ACCOMMODATIONS

This form is to be completed by the individual requesting a reasonable accommodation.

General Information:

Name______________________ QCC ID # ______________________

Position Title______________________________________________

Department/School_________________________________________

Home Address

____________________________________________________________

____________________________________________________________

Campus Address______________________________________________

Mail Code __________

Home Telephone__________________ Campus Telephone____________

Email______________________________________________

How would you prefer to be contacted?

Home Phone_____ Office Phone_____ Email_____

Classification:

- Full-time
- Part-time
- Temporary/Contract
- Faculty
- Admin/Professional Staff
- Support Staff
- Service/Maintenance
This form is to be completed by the individual requesting a reasonable accommodation.

1. What is the nature of your disability?
   - Mobility Impairment
   - Physical Disability – Other
   - Visual
   - Hearing
   - Mental/Emotional
   - Learning
   - Cognitive
   - Chronic Illness
   - Speech
   - Other

2. Is this a permanent or temporary condition?

3. What work-related limitations caused by your condition are you currently experiencing? Please provide as much detail as you believe is relevant.

4. Please describe the accommodations you are requesting. Please be as specific as possible.

5. What, if any, adaptive equipment or workplace modifications are you requesting?

6. What are the essential functions of your job and how will the requested accommodation(s) assist you in performing them?

Name of Treating Physician______________________________________________

Address__________________________________________________________

Phone________________________

I understand that by making this request, I am authorizing the Director of Personnel to discuss information regarding any required accommodations with my immediate supervisor or his/her supervisors and that all information regarding my disability and reason for accommodations will remain strictly confidential. I also understand that when reasonable accommodations have been provided, I will be held to the same performance, conduct and attendance standards as all other QCC employees.

Signature__________________________________________ Date______________

File Number __________________________
This form is to be completed by the individual requesting a reasonable accommodation.

So that we may properly evaluate your request for reasonable accommodations for your disability, please have your qualified medical provider complete this form and return it directly to us at the address listed below.

This form, and the information contained on it, will be kept separate from your personnel file and will remain confidential. I, __________________________, authorize my physician, or any other professional clinician who may share in my care, to release to the designated representative of the Queensborough Community College any and all information which shall be required with respect to my disability and the accommodations being requested.

I understand that: 1) this authorization will expire on the day my employment at the Queensborough Community College expires; 2) that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on this authorization; 3) that my provider may not refuse to treat me if I refuse to sign this authorization; and 4) that once this information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s), and may no longer be protected by federal privacy regulations.

I give this authorization voluntarily and with full understanding of its nature.

Name _________________________________ Job Title _________________________________

QCC ID ________________________________

Date _________________________________

Signature ______________________________
Disability Documentation Form – Page 2

This form is to be completed by the Qualified Medical Provider

1. What is the covered disability for which accommodations are being requested?

2. What major life activity is significantly limited by the disability? Please describe the limitations.

3. Please explain how the employee’s disability impacts his/her ability to perform the essential functions of his/her job at the Queensborough Community College (see attached job description.).

4. If the employee’s disability prevents him/her from performing any of the essential functions of his/her position, please identify any accommodations that could be made to assist the employee in performing these functions.

5. Is there any additional information that you think is relevant to our evaluation of this employee’s request for reasonable accommodations at the Queensborough Community College expires?

Name (Print)_____________________________ Phone________________
Signature_____________________________
License Number______________________ Issuing State_____________________
Address_________________________________________________________________
City____________________________________________ State_____ Zip__________

Please return this form directly to the Office of Personnel, Queensborough Community College, 222-05 56th Ave. Room: 412 Admin. Bldg Bayside, New York 11364 or Fax to (718) 631-6264. If you have any questions, contact us at (718) 631-5028. We appreciate your assistance.
Queensborough Community College Program
For Persons with Disabilities and Covered Veterans

VOLUNTARY SELF-IDENTIFICATION FORM
(For Use Only by Current QCC Faculty and Staff)

The Queensborough Community College (QCC) complies with Section 503 of the Rehabilitation Act of 1973, as amended, and the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended. Both laws require that QCC adopt affirmative action programs and take affirmative action to employ and advance in employment qualified individuals with disabilities and covered veterans (i.e. qualified individuals who are special disabled veterans). QCC also complies with the Americans with Disabilities Act of 1990 and the Veterans Employment Opportunities Act of 1998.

Additionally, each year QCC must submit its annual VETS-100 Report on the employment of target veterans (see categories and definitions below) to the U.S. Department of Labor.

As part of QCC's affirmative action program, current Queensborough Community College faculty and staff are invited to identify their disability and/or covered veteran status to the Office of Personnel. Completion of this form is voluntary. Refusal to complete and return this self-identification form will not subject you to any adverse treatment nor will the information provided be used in any manner inconsistent with the law. The information you provide is kept confidential, except that

1. Administrators, managers, and supervisors may be informed of any work restrictions or reasonable accommodations;

2. First aid or safety personnel may be informed, to the extent necessary, to administer any emergency treatment; and

3. Government officials may be informed as they investigate/audit QCC’s compliance with the law.

Current faculty and staff may identify their disability and/or veteran status at any time during the course of employment with QCC. If you would like to let us know whether you are a disabled individual or a special disabled veteran, we invite you to complete this form [https://www2.qcc.cuny.edu/personnel/voluntaryselfidform.aspx](https://www2.qcc.cuny.edu/personnel/voluntaryselfidform.aspx) and it will be sent via email to the Office of Personnel or you can complete the form print it and mail it to the attention of: Queensborough Community College Office of Personnel Room 412 Administration Building Bayside, NY 11364.