CONFIDENTIAL

ACCOMMODATION RECORD

The Update Form (page 5) is to be submitted annually in subsequent years.

Date Submitted: ___/___/___

Name: Last _____ First _____ M.I. _____ Pass No. _____

Department/Division: _____ Job Title Sought/Held: _____

Location: _____ Telephone: _____

Will it allow the employee to do the essential functions of the job? Yes ☐ No ☐

Comments: _____

_____

_____

Do you anticipate the need to make changes regarding the accommodation? Yes ☐ No ☐

If YES, please describe: _____

_____

_____

_____

_____

Submitted by: _____ _____

Employee (Print Name) Employee Signature

_____ _____ _____

Supervisor (Print Name) Supervisor Signature Supervisor Title

Supervisor's Telephone Number _____ Date ___/___/___

ACCOMMODATION RECORD — CONFIDENTIAL

Name: Last _____ **First** _____ **M.I.** ___ **Pass No.** _____

Check One: (✓)

- ☐ Employee seeking new position?
- ☐ Employee seeking accommodation in current title?
- ☐ Applicant for new hire from certified list?
- ☐ Applicant for new hire: non-list?

Disability Data: Circle all that apply. If the appropriate item is not listed, specify *Other.*

A	Amputee - ambulatory	**H**	Hearing	**S**	Speech
B	Amputee - non ambulatory	**K**	Multiple Sclerosis	**T**	Tuberculosis
C	Cancer	**L**	Leukemia	**V**	Vision
D	Diabetes	**M**	Mental Impairment	**X**	Cerebral Palsy
E	Epilepsy	**O**	Orthopedic	**Z**	Emphysema
F	Muscular Dystrophy	**P**	Paralysis-ambulatory	**Other:**	_____
G	HIV Infection	**Q**	Paralysis-non ambulatory		_____

Briefly describe individual's impairment in reference to essential functions of job:

_____

_____

_____

_____

Briefly describe potential accommodations considered, if any (including those requested by employee)

_____

_____

_____

_____

Was a reasonable accommodation identified and made? **Yes** ☐ **No** ☐

If "Yes" describe the reasonable accommodation made: (Date and description of action). ___/___/___

_____

_____

_____

_____

_____

_____

_____

_____

ACCOMMODATION RECORD *CONFIDENTIAL*

THIS PAGE IS NOT TO BE RETAINED BY DEPARTMENTS

If a reasonable accommodation was not made because of the cost of the accommodation, what was the individual's response to an offer from NYCT to allow the individual to pay for the accommodation?

_____

_____

_____

_____

The following information is to be recorded for statistical purposes only:

Name: Last _____ First _____ M.I. ___ Date: ___/___/___

Work Address _____ Pass No. _____

Please Check (✓)

Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Hispanic ☐ American Indian
☐ Black ☐ Asian ☐ Other

Veteran Status ☐ Veteran ☐ Non-veteran

Is the incumbent a veteran of the Vietnam era? (Did any part of the incumbent's military service fall during the period Jan. 1, 1963-May 7, 1975?) **Yes** ☐ **No** ☐

To be completed by the ADA Compliance Officer

How much did the accommodation cost? $_____

Any additional cost? $ _____ Savings to date $ _____

Which, if any, of the following benefits where realized?

☐ Eliminated the cost of training a new employee
☐ Saved worker's compensation and/or other insurance costs
☐ Increased worker's productivity
☐ Other. specify: _____ _____

If quantifiable, estimate the value of the savings or other benefit derived.
$_____.

ACCOMMODATION RECORD *CONFIDENTIAL*

Name: Last _____ **First** _____ **M.I.** ____ **Pass No.** _____

START DATE: ___/___/___ **DOB:** ___/___/___

Work Address _____

ILLNESS REPORTED: _____

DATE REPORTED: ___/___/___ ☐ Submitted with **original** medical Rx form or letter.

Doctor/State Certified Healthcare Professional Information:

Name _____ **Telephone** (_____)_____

Address: _____

RECOMMENDATION:

_____

_____

_____

_____

SUBSEQUENT ILLNESSES SINCE FIRST REPORT:

_____

_____

_____

_____

COMMENTS:

_____

_____

_____

CONFIDENTIAL

ACCOMMODATION RECORD

ANNUAL UPDATE

(To be completed every 12 months by Departmental HR Representative and sent to the ADA Compliance Officer with a copy to Job Accommodation Coordinator, Employment.)

Date Submitted: ___/___/___

Name: Last _____ First _____ M.I. _____ Pass No. _____

Work Address: _____ Dept./Division: _____

Job Title Held: _____ Location: _____

Date original Accommodation Record submitted: ___/___/___

Does it allow the employee to do the essential functions of the job? Yes☐ No☐

Comments: _____

Have changes been made or do you anticipate the need to make changes regarding the accommodation? Yes☐ No☐
Please describe if YES: _____

_____

Does the accommodation continue to be reasonable? Yes☐ No☐
If NOT, explain why, what actions were taken and when.

_____

_____

Submitted by: _____ _____
Employee (Print Name) Employee Signature

_____ _____ _____
Supervisor (Print Name) Supervisor Signature Supervisor Title

Telephone Number: (_____) _____ Date: ___/___/___