



**NASSAU COMMUNITY COLLEGE  
REQUEST FOR REASONABLE ACCOMMODATION**

This form provides standard written documentation of an employee's request for a reasonable accommodation. It is to be completed and signed by the employee and his/her/their Department Head/Supervisor, in consultation with the Area Vice President, and submitted to the Affirmative Action, ADA/504 Officer at [aao@ncc.edu](mailto:aao@ncc.edu). Completing this form is not a guarantee that the request will be granted, and approved accommodations are subject to annual review.

Request From: \_\_\_\_\_ Date: \_\_\_\_\_

Position/Title: \_\_\_\_\_ Office Ext: \_\_\_\_\_

Department: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**PLEASE BRIEFLY ANSWER QUESTIONS 1-5 BELOW:** (Continued on page 2 of form).

1. What is your disability? What, if any, job function are you having difficulty performing?

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2. How does your disability impact your daily living outside of work?

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3. How does the disability impact your ability to perform your duties at work?

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4. Describe what you think will help you effectively perform your job and how that accommodation will assist you.

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5. Please attach your medical documentation for your reasonable accommodation request.  
(Do not copy anyone when submitting medical documentation.)

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

\_\_\_\_\_  
Print/Type Employee Name

\_\_\_\_\_  
Date

**To be completed by Department Head/Supervisor, in consultation with the Area Vice President:**

Would the requested accommodation, if granted, fundamentally alter the position of, or impact, any other employee's job duties or position? Yes [ ] No [ ]

If yes, please explain and/or provide any other relevant information.

\_\_\_\_\_  
Signed: Dept. Head/Supervisor      Date

\_\_\_\_\_  
Signed: Area Vice President      Date

Title: \_\_\_\_\_

Title: \_\_\_\_\_

*(The department supervisor is responsible for implementing the accommodation, subject to approval.)*

**For Affirmative Action Office Use Only:**

**Action(s) taken:**

\_\_\_\_\_  
Date Reviewed by AAO

- A. Interactive Process – Meeting held with Requestor, department supervisor, and Area VP or designee -- union representatives may be present.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Conference Date (if applicable)

\_\_\_\_\_  
Initial

Outcome: \_\_\_\_\_

- B. Granted/Approved \_\_\_\_\_ C. Disapprove \_\_\_\_\_

\_\_\_\_\_  
Affirmative Action, ADA/504 Officer

\_\_\_\_\_  
Date

**\*Approved accommodations are subject to review and will require updated medical documentation and an updated request form.**