

Disability Accommodations Request Form

Notice and Understanding Concerning Request for a Reasonable Accommodation

Accommodation Request:

I, _____, acknowledge and agree that if I revoke an authorization to release health information addressed to a health care provider and signed by me for purposes of permitting that health care provider to release certain information to Durham Technical Community College in support of my request for a reasonable accommodation, I may not revoke any action that Durham Technical Community College may have taken in reliance upon information disclosed, pursuant to the authorization prior to the date of my revocation. I also understand that the federal Americans with Disabilities Act and other applicable federal, state, and local laws require me to be an active participant in the interactive process and to provide Durham Technical Community College with my health information that is necessary to determine whether I am eligible for a reasonable accommodation and, if so, what the reasonable accommodation will be. If I fail to cooperate in the interactive process or fail to provide the necessary medical information, I understand that I will not receive a reasonable accommodation.

I understand that the information provided by a health care provider will become an employment record and will be retained by Durham Technical Community College as required by law. I understand that the Health Insurance Portability and Accountability Act does not apply to an employment record and the director of Human Resources of Durham Technical Community College may disclose the information to others with a business need to know for the purpose of evaluating alternative reasonable accommodations and implementing an appropriate reasonable accommodation. Durham Technical Community College, however, will comply with the requirements of the Americans with Disabilities Act and other applicable federal, state, and local laws concerning the confidentiality of the information provided to it pursuant by my health care providers.

I acknowledge that (i) I have read and understand this notice and (ii) I have received a copy of this notice for my own records.

Employee's Signature

Date