REASONABLE ACCOMMODATION FORM – DISABILITY

Please complete this form if you have a physical or mental health disability and need a reasonable accommodation to perform the essential functions of your position or to participate in the hiring process. Should you need any help completing this form, or if you have any questions about this form or PSEG's reasonable accommodation policy, please speak to the Company's Affirmative Action Compliance Manager at 973-430-6540. This form should be returned directly to the Medical Department, 80 Park Plaza, T-2C, Newark, New Jersey 07102, Attention: Manager of Occupational Health Services. FOR CURRENT EMPLOYEES, THIS FORM SHOULD NOT BE RETURNED TO YOUR MANAGER OR TO ANYONE AT YOUR LOCATION.

EMPLOYEE/APPLICANT NAME: _____

EMPLOYEE IDENTIFICATION NUMBER:_____

DEPARTMENT: _____

LOCATION:_____

POSITION: _____

1. Please describe the accommodation(s) you are requesting. If there is more than one accommodation that you believe will meet your needs, please describe all possible accommodations.

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2. Please describe your medical condition and the reason(s) why you are requesting an accommodation. For current employees, include a description of the essential functions of your job that you currently are unable to perform, and explain how the requested accommodation(s) will enable you to perform those essential functions of your job.

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Employee/Applicant Name:_____

3. For how long will the requested accommodation(s) be needed. _____

4. Please attach to this form any documentation that you believe supports your need for the requested reasonable accommodation. Please also provide any other information that you believe is relevant to your request.

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I certify that the information contained on this form and submitted with this form is true and correct.

_____ _____

Signature *Date*

PLEASE RETURN THIS FORM TO THE MEDICAL DEPARTMENT, 80 Park Plaza, T-2C, Newark, New Jersey 07102, ATTENTION: MANAGER OF OCCUPATIONAL HEALTH SERVICES. FOR CURRENT EMPLOYEES, DO NOT GIVE THIS FORM TO YOUR MANAGER OR TO ANYONE AT YOUR LOCATION AS IT MAY CONTAIN CONFIDENTIAL MEDICAL INFORMATION.

CERTIFICATION OF HEALTH CARE PROVIDER
FOR REASONABLE ACCOMMODATION

Patient's Name: _____

Date Condition Commenced: _____

Probable Duration of Condition: _____

This certification will be used for the purpose of assessing whether your patient has a disability that would benefit from a reasonable accommodation within the workplace. Please base your assessment on your patient's present abilities or limitations in performing the essential functions of his/her current position as described to you.

1. Does your patient have a disability?[1] ☐ Yes ☐ No

2. If you answered "yes" to question #1, is your patient able to perform each of the essential job functions described **without** reasonable accommodation(s)? ☐ Yes ☐ No

3. If you answered "no" to question #2, would your patient be able to perform each of the essential job functions described **with** reasonable accommodation(s)? ☐ Yes ☐ No

4. If you answered "yes" to question #3, please provide the following information: a) state which essential function(s) of the job require an accommodation; b) for each such essential function, any recommendations you have for reasonable accommodation(s). If there is more than one recommended accommodation, please describe all possible accommodations; c) explain why the disability requires this accommodation to allow the employee to perform the essential function(s).

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[1] A disability is a condition that imposes a substantial limitation on a major life activity. By way of example, "major life activities" include, but are not limited to, standing, sitting, walking, lifting, talking, interacting with others, eating, breathing, hearing, seeing, speaking, working and learning.

Disability also means a physical disability, infirmity, malformation or disfigurement which is caused by bodily injury, birth defect or illness including epilepsy and other seizure disorders, and which shall include, but not be limited to, any degree of paralysis, amputation, lack of physical coordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment or physical reliance on a service or guide dog, wheelchair, or other remedial appliance or device, or any mental, psychological or developmental disability resulting from anatomical, psychological, physiological or neurological conditions which prevents the normal exercise of any bodily or mental functions or is demonstrable, medically or psychologically, by accepted clinical or laboratory diagnostic techniques. Disability shall also mean AIDS or HIV infection.

Patient/Employee's Name:_____

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Print or type clearly the name and address of the Health Care Provider completing this form:

Name: _____

Address: _____

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Telephone: _____

Facsimile: _____

E-mail Address:_____

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Signature of Health Care Provider Date

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