BERS Board of Education Retirement System of the City of New York

SANFORD R. RICH
EXECUTIVE DIRECTOR

DANIEL D. MILLER
DEPUTY EXECUTIVE DIRECTOR

To**: All BERS Employees**

From**: Sanford Rich Executive Director** Sanford Rich

Subject: **Reasonable Accommodation Statement**

The NYC Board of Education Retirement System (BERS) is committed to fostering an inclusive workplace by providing reasonable accommodations to qualified employees and applicants. Accommodations are provided for **disabilities, religious observances, pregnancy, childbirth or related medical conditions, and status as a victim of domestic violence, sexual offenses, or stalking**, provided such accommodations do not impose an undue hardship on the agency.

This commitment reflects compliance with federal, state, and local laws, ensuring all individuals can perform essential job functions and enjoy equal employment opportunities.

Requesting an Accommodation

Employees or applicants seeking a reasonable accommodation should contact the agency's **EEO Office** directly. This approach ensures confidentiality and streamlines the process. Supervisors are not required as an initial point of contact but may be consulted during the implementation phase if necessary.

Examples of Reasonable Accommodations:

- Use of assistive devices such as visual aids or ergonomic chairs.
- Flexible or modified work schedules.
- Telework arrangements due to medical conditions.
- Adjustments for religious practices or observances.

Timeframes for Processing Requests

1. **Standard Requests:**
   Requests are typically reviewed and resolved by the EEO Office within **10 business days** if the accommodation does not require extensive evaluation or consultation.
2. **Expedited Requests:**
   In urgent situations—such as medical emergencies or preventing imminent harm—the EEO Office prioritizes and resolves these requests within **10-15 business days**, depending on the urgency.

Granting Accommodations

Each request is evaluated on an individual basis. The EEO Office collaborates with the employee, considering their functional limitations, the job's essential functions, and the feasibility of the requested accommodation.

Process Details:

- If a reasonable accommodation is identified, the EEO Office will communicate the details to the employee and their supervisor (if necessary).
- Accommodation may be reevaluated, modified, or terminated based on changing circumstances.

Notification of Determination

The decision regarding an accommodation request will be provided in writing and include:

- Approval or denial details.
- Next steps for implementation or alternative solutions.

A copy of the determination will be maintained confidentially and recorded in DCAS' Citywide Complaint/Reasonable Accommodation Tracking System.

Important Notes

- Requests for **remote work** solely for caregiving purposes (e.g., caring for a child or household member) are not covered under the reasonable accommodation policy. Employees should consult their supervisor to explore leave options or alternative arrangements.
- Employees or applicants are encouraged to contact the **EEO Office** to ensure their accommodation needs are met through a cooperative dialogue.

Commitment to Confidentiality

BERS prioritizes the confidentiality of all accommodation requests. Information is shared only on a need-to-know basis to implement approved accommodations or for compliance purposes.

For assistance or to submit a request, please contact:

- **Principal EEO Officer : Michael Sohn. msohn2@bers.nyc.gov**
- **Deputy EEO Officer: Lydia Ahmim. lahmim@bers.nyc.gov**

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A. Reasonable Accommodation Request Form

This form and all information must be kept confidential.

NAME AND CONTACT INFORMATION		
Print full name	☐ Current employee ☐ Job applicant ☐ Other (please specify)	
Home or work address:	**Phone number**	
EMPLOYEE INFORMATION (Complete this section only if you are an employee)		
Civil service title	**Office title**	
Office telephone number	**Email address**	
Supervisor name	**Phone number**	**Supervisor email address**
Division	**Worksite/location**	
APPLICANT INFORMATION (Complete this section only if you are a job applicant)		
Position/title sought	**Division/unit (if known)**	
Location of position (if known)		
Part(s) of the employment process for which an accommodation is requested (please check the box below):		
☐ **Job application** **Job vacancy notice number (if known):**		
☐ **Interview** **Interview date:**		
☐ **Other (please specify):**		
Agency contact person (if known)		**Phone number**

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Basis of reasonable accommodation request:

- ☐ **Disability**
- **Religion**
- ☐ **Status as victim of domestic violence, sex offenses, or stalking**
- ☐ **Pregnancy, childbirth, or a related medical condition**
- ☐ **Lactation needs**

Is the condition for which you are requesting an accommodation:

Permanent **Temporary** **Unknown**

If temporary, anticipated date accommodation(s) no longer needed:

Identify the situation that requires accommodation and describe the nature of reasonable accommodation requested and how the accommodation will assist you to perform the essential functions of the position held or desired, or to enjoy the benefits and privileges of employment. Please be specific. (Attach additional sheets and present supporting documentation as appropriate.)

If equipment is requested, please specify brand, model number and vendor, if known.

For reasonable accommodation requests based on disability, you may be asked to provide additional medical documentation to better assess your need.

<u>This CONFIDENTIAL documentation should be provided to the Disabilities Rights Coordinator or EEO officer</u>

Such documentation should:

- ☐ **Be dated and signed by the health professional. (e.g., M.D., D.O., etc.)**
- ☐ **Describe the severity of the disability and its limitations in detail as they currently exist and how they limit the individual's ability to perform the essential functions of the job.**
- ☐ **Indicate the extent to which the accommodation will permit you to perform the essential functions of the job or to enjoy the benefits and privileges of employment.**
- ☐ **State whether the duration of disability is permanent or temporary or unknown.**
- ☐ **If temporary, specify the date the disability is expected to no longer require accommodation.**

I certify that I have read and understood the information provided in this request, and that it is true to the best of my knowledge, information, and belief.

Date	**Requestor's signature/authorized agent**

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B. Authorization for Release of Health Information Pursuant to HIPAA

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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C. Reasonable Accommodation Request Record of Steps and Outcome

REASONABLE ACCOMMODATION REQUEST RECORD OF STEPS AND OUTCOME	
Name of applicant/employee:	**Telephone number:**
Address:	
Request number:	**Received by:**
Date received:	**Received by:**
Method of filing: ☐ **In Person** ☐ **Phone** ☐ **Mail** ☐ **E-mail**	
DOCUMENTATION OF STEPS TAKEN TO CONSIDER REQUEST	
DATE:	**COMMENTS:**

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RESOLUTION	
☐ **Granted** **Date:**	**Type of accommodation granted:** ☐ **As requested** **Different from what was requested** **Please provide specifics: (Attach additional sheets as needed.)**
☐ **Denied** **Date:**	**Reason for denial:**
Date when letter granting or denying the requested accommodation was sent to employee or applicant:	

Signature_____**Date:**_____

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D. Granting of Reasonable Accommodation Request

GRANTING OF REASONABLE ACCOMMODATION REQUEST (To be completed by deciding official)
1. Full name of individual requesting reasonable accommodation:
2. Basis for reasonable accommodation request:
☐ Disability ☐ Religion ☐ Status as victim of domestic violence, sex offenses, or stalking ☐ Pregnancy, childbirth or a related medical condition ☐ Lactation needs
3. Specific accommodation requested:
4. Decision:
☐ Reasonable accommodation granted as requested ☐ Alternative accommodation granted
Describe accommodation granted:
Deciding official name (print): _____ Signature: _____ Date granted: _____ Telephone: _____ Email: _____
cc: EEO officer, and if applicable, agency personnel officer, manager/supervisor.

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E. Denial of Reasonable Accommodation Request

DENIAL OF REASONABLE ACCOMMODATION REQUEST (To be completed by deciding official)
1. Name of individual requesting reasonable accommodation:
2. Basis for reasonable accommodation request:
☐ Disability ☐ Religion ☐ Status as victim of domestic violence, sex offenses, or stalking ☐ Pregnancy, childbirth, or a related medical condition ☐ Lactation needs
3. Specific accommodation request:
4. Request for reasonable accommodation denied because (you may check more than one box).
☐ Employee's request determined not to be related to a disability ☐ Employee's request determined not to be related to religion ☐ Employee determined not to be a victim of domestic violence, sex offenses, or stalking ☐ Employee's request determined not to be related to pregnancy, childbirth, or related medical condition ☐ Employee's request determined not to be related to a lactation need ☐ Accommodation would not meet requested need ☐ Accommodation would cause undue hardship ☐ Documentation of need for the accommodation inadequate ☐ ☐ Accommodation would require removal of an essential function of the job ☐ Accommodation would pose direct threat ☐ Other (please specify)

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5. Reason(s) for the denial of reasonable accommodation (must be specific, e.g., why accommodation is ineffective or causes undue hardship).
6. If the individual proposed one type of reasonable accommodation, which is being denied, but rejected an offer of a different type of reasonable accommodation, explain both the reasons for denial of the requested accommodation and reason why chosen accommodation would be effective.
7. Appeal: Where an employee or applicant has requested a reasonable accommodation consistent with these procedures and the agency representative has not provided the reasonable accommodation, an appeal may be made to the agency head or their designee within 10 days from when the EEO Office issues the decision.
8. If a job applicant or employee wishes to file an internal EEO complaint, they must contact (name), the agency EEO officer (provide contact information).
Deciding official **Name (print):** _____ **Telephone:** _____ **Email:** _____
Signature: _____ **Date denied** _____
cc: EEO officer, and if applicable, agency personnel officer, manager/supervisor.