PEMBERTON TOWNSHIP SCHOOLS
You can get there from here!

JANNETT PACHECO
Director of Human Resources

JEFFREY HAVERS
Superintendent

How to apply for a 504:

Please be advised that in accordance with the provisions of Section 504 of the Rehabilitation Act of 1973, you are requesting a 504 Plan, or a continuation of an existing 504 Plan. In order for the 504 Committee to review your request, it will be necessary for your **physician** to complete the **Physician Certification Form** and for **you** to complete the **Employee Accommodation Request Form**. Additionally, enclosed for your review is the "Rights of Persons with Handicaps or Disabilities". Even if you have an approved 504 plan, you must **re-apply annually**.

The completed forms should be sent directly to the attention of the District 504 Staff Compliance Officer, as soon as possible, so that we may have your plan in place for you for the school year, if appropriate. As soon as the forms are received, the 504 Accommodation Team will convene and a determination will be made with respect to the provision of a 504 Plan. Submit these forms and attached documentation in a sealed envelope marked CONFIDENTIAL to:

INTEROFFCE:
Human Resources Department
District 504 Staff Compliance Officer
Brotherhood Administration Building

or

U.S. MAIL:
Human Resources Department
Pemberton Township Schools
Brotherhood Administration Building
PO Box 228 One Egbert Street
Pemberton, NJ 08068

Should you have any questions regarding the above, please feel free to call me at 609-893-8141 ext.1021

Sincerely,

Jannett Pacheco
Director of Human Resources

Enclosures (4): Physician Certification Form
Employee Accommodation Request Form
Rights of Person with Handicaps or Disabilities
Employee's Authorization to Release Medical Information Form

Pemberton Township Schools

EMPLOYEE'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THIS FORM SHOULD BE USED WHEN RELEASE OF AN INDIVIDUAL'S PROTECTED HEALTH INFORMATION IS BEING MADE TO ANYONE FOR A PURPOSE OTHER THAN TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

(1) I, _____ hereby authorize the use or disclosure of my health information as described in this authorization.

- ❑ Any and all records pertaining to my **Leave of Absence/FMLA/NFLA/504 Plan** in the possession of (**physician's name, telephone number, and fax number**)
  _____
  _____
  _____,
  including physical examination results and/or psychiatric/psychological evaluation results.

- ❑ Other [please specify - include dates]
  _____
  _____
  _____.

(2) Specific person/organization (or class of persons) authorized to receive and use the information:

Ms. Jannett Pacheco, Director of Human Resources

Pemberton School District Board of Education

(3) Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying the health care provider in writing at the current address. I understand that the revocation is only effective after it is received and logged by the health care provider. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(4) I understand that after this information is disclosed, Federal law might not protect it and the recipient might re-disclose it.

(5) I understand that I am entitled to receive a copy of this authorization.

Signature of Patient _____ Date _____

Rights of Persons with Handicaps or Disabilities

DEFINITIONS:

Handicapped Person – means any person who (1) has a physical or mental impairment that substantially limits one or more of a person's major life activities and includes specific learning disabilities, (2) has a record of such impairment, or (3) is regarded as having such impairment. (34 CFR sec. 104.3(j))

Mental or Physical impairment – means (1) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; muscular skeletal, special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (2) any mental or physiological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. (34 CFR sec. 104.3(j)(2)(i))

Major life activities – means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.
(34 CFR sec. 104.3(j)(2)(ii))

Has a record of such impairment – means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities. (34 CFR sec. 104.3(j)(2)(iii))

Is regarded as having an impairment – means (1) has a physical or mental impairment that does not substantially limit major life activities but that is treated by a recipient as constituting such a limitation; (2) has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment, or (3) has none of the impairments defined about, but is treated by a recipient as having such an impairment. (34 CFR sec. 104.3(j)(2)(iv))

Recipient – Any state or its political subdivision, including this Board of Education.
(34 CFR sec. 104.3(f))

Qualified handicapped person – means:

1. With respect to employment, a handicapped person who, with reasonable accommodation, can perform the essential functions of the job in question;

2. With respect to public preschool elementary, secondary, or adult educational services, a handicapped person (1) of an age during which non-handicapped persons are provided such services, (2) of any age during which is mandatory under state law to provide such services to handicapped persons, or (3) to whom a state is required to provide a free appropriate public education under section 612 of the Education of the Handicapped Act;

3. With respect to post-secondary and vocational educational services, a handicapped person who meets the academic and technical standards requisite to admission r participation in the school district's education program or activity; and

4. With respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services.
(34 CFR sec. 104.(k)(1-4))

Handicap – means any condition or characteristic that renders a person handicapped person as defined. (34 CFR sec. 104.3(1))

Aids, benefits, and services – means aids, benefits and services to be equally effective, are not required to produce the identical result or level of achievement for handicapped and non-handicapped persons, but must afford handicapped persons equal opportunity to obtain the same result, gain the same benefit, or reach the same level of achievement, in the most integrated setting appropriate to the person's needs. (34 CFR sec. 104.4(b)(2))

Act – means the Rehabilitation Act of 1973, Public Law 93-112, as amended by the Rehabilitation Act Amendments of 1974. Public Law 93-516, 29 U.S.C. 794.

If you have questions or concerns on the action taken by the Section 504 Committee please contact the District's **Director of Human Resources**, Pemberton Township Schools, PO Box 228 - One Egbert Street, Pemberton, NJ 08068, (609) 893-8141 ext. 1021 and a meeting will be arranged.

You also have the right to file a complaint with the The State of New Jersey, Division on Civil Rights, P. O. Box 090, Trenton, NJ 08625.

The address that covers this school district's Affirmative Action Officers* is **Affirmative Action Office, Pemberton Township Schools, PO Box 228, Pemberton, NJ 08068.**

- **Jannett Pacheco, Affirmative Action Officer**

PEMBERTON TOWNSHIP SCHOOL DISTRICT
SECTION 504 ACCOMMODATION(S) PHYSICIAN CERTIFICATION FORM
2026-2027 School Year

EMPLOYEE NAME: _____ DATE OF REQUEST: _____
POSITION: _____ WORK LOCATION: _____
ADDRESS: _____

TO BE COMPLETED BY PHYSCIAN/PSYCHIATRIST/PSYCHOLOGIST

A. DISABILITY

1. Does the person have a mental or physical impairment? ☐ Yes ☐ No
   If yes, specify the mental or physical impairment of the employee:
   _____

2. Does the mental or physical impairment stated in A.1. impact a major life activity of the employee?

   If Yes, check the **major life activity** impacted by the mental or physical impairment:

   ☐ Breathing ☐ Hearing ☐ Walking ☐ Learning ☐ Speaking

   ☐ Seeing ☐ Lifting ☐ Standing ☐ Sitting ☐ Working

   ☐ Performing manual tasks ☐ Caring for Oneself

   ☐ Other If Other please specify _____

3. State the approximate date the condition commenced and the probable duration of the condition: _____

4. Is the condition a chronic condition? _____

5. Is the employee required to receive any type of treatment for his/her condition? If so, please describe the treatment below:

   _____
   _____
   _____
   _____

6. Place an "X" on the following scale to indicate the specific degree that the impairment stated in item A.1. limits the major life activity checked in A.2.
Guideline In Completing Scale

- An impairment substantially limits a major life activity if the individual is unable to perform or is significantly limited in the ability to perform the activity compared to an average person in the general population. Factors to consider are: nature and 'severity of the impairment; how long it will last, or is expected to last; and its permanent or long-term impact or expected impact.

- Use the average person in the general population as the frame of reference for purpose of comparison.

- If the major life activity is "working," a person will generally not be considered to be substantially limited in working if she/he is substantially limited in performing only a particular job for one employer or unable to perform a very specialized job in a particular field. The person must be significantly restricted in the ability to perform either a class of jobs or a broad range of jobs in various classes.

- Temporary, non-chronic impairments that do not last for a long time and that have little or no long term impact usually are not disabilities. Consider extent, duration and impact of the impairment.

Scale

For an "X" at 4.0 or above, fill in specific information evaluated by the committee that justifies the rating:

5 ____ Extremely _____

4 ____ Substantially _____

3 ____ Moderately _____

2 ____ Mildly _____

1 ____ Negligibly _____

7. Does the employee meet the necessary prerequisites for the position: (e.g. education, work experience, training, skills, licenses, certificate(s) based upon the attached job description.

	Yes		No

If no, please explain.

8. Can the employee perform the essential functions of the position unaided? (i.e., without need for reasonable accommodation).

☐ Yes ☐ No

9. If the employee cannot perform the essential functions of the position unaided, can the employee perform the essential functions of the job with reasonable accommodation?

☐ Yes ☐ No

10. If the employee is unable to perform the job functions of your position without accommodation, please state the functions that he/she is not able to perform.

11. State the circumstances surrounding the employee's inability to perform the functions identified in #9 (e.g., frequency, duration).

12. What accommodation are you requesting on behalf of the employee?
(Be specific as possible)

13. What suggestions do you have of possible alternative accommodation(s) to those identified in #12 that the school district may consider?

14. Identify the reasonable accommodation(s) that you considered and either accepted or rejected for the employee:

Specify Accommodation	Accepted	Rejected	Reason If Rejected
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

15. **SUMMARY**

a. Does the person have a DISABILITY? ☐ Yes ☐ No

b. Is the person a QUALIFIED INDIVIDUAL? ☐ Yes ☐ No

c. What accommodation(s), if any, are you recommending that the employee be provided by the school district?

I hereby certify that the information contained herein is accurate and truthful. I further understand and certify that if any of the statements contained therein are willfully false, I am subject to punishment.

Physician's signature/stamp _____ Date _____

(Area of Medical Specialization) _____ Telephone Number _____

PEMBERTON TOWNSHIP SCHOOLS

Section 504/ADA Employee Accommodation Request
2026 – 2027 School Year

EMPLOYEE NAME: _____ DATE OF REQUEST: _____

ADDRESS: _____

POSITION: _____ WORK LOCATION: _____

1. Specify the **mental or physical impairment** you claim to have.

_____
_____
_____
_____

2. Check the **major life activity** you claim is impacted by the physical or mental impairment referred in # 1.

☐ Breathing ☐ Hearing ☐ Walking ☐ Learning ☐ Speaking

☐ Seeing ☐ Lifting ☐ Standing ☐ Sitting ☐ Working

☐ Performing manual tasks ☐ Caring for Oneself

☐ Other If Other please specify _____

3. Do you claim that the mental or physical impairment referenced in #1 substantially limits the major life activity referenced in #2?

	Yes		No

If the answer is Yes, please state how the mental or physical impairment substantially limits the major life activity. (Be as specific as possible).

_____
_____
_____
_____

4. Are you undertaking any measures that mitigate the impact of the mental or physical impairment on the major life activity? (e.g. medication, glasses)

_____
_____

5. Are you able to perform the job functions of your position without accommodation?

6. If you are unable to perform the job functions of your position without accommodation, please state the functions that you are not able to perform.

7. State the circumstances surrounding your inability to perform the functions identified in #6 (e.g., frequency, duration).

8. What accommodation are you requesting? (Be specific as possible)

9. What suggestions do you have of possible alternative accommodation(s) to the one identified in #8 that the school district may consider?

Attach adequate documentation (e.g., medical, psychological, diagnostic, etc.) of the disability and/or need for reasonable accommodation.

Submit this form and attached documentation in a sealed envelope marked CONFIDENTIAL to:

INTEROFFICE:
Director of Human Resources
District 504 Staff Compliance Officer
Brotherhood Administration Building

or

U.S. MAIL:
Director of Human Resources
Pemberton Township Schools
Brotherhood Administration Building
PO Box 228 - One Egbert Street
Pemberton, NJ 08068-0228

Employee's Signature

Date