CONNER STRONG & BUCKELEW

PRIVILEGED AND CONFIDENTIAL
ACCOMMODATION REQUEST FORM

Conner Strong may request that this form be used by employees who are seeking reasonable accommodations for a disability (whether permanent, temporary, or pregnancy-related) under the Americans with Disabilities Act (ADA), the New Jersey Law Against Discrimination (LAD), the New Jersey Pregnant Workers Fairness Act (PWFA), or any other federal, State, or local accommodation law to help facilitate an interactive accommodation process.

I. TO BE COMPLETED BY EMPLOYER:

Employer's Name: Conner Strong & Buckelew Companies, LLC

Date:

Employee's Name:

Employee's Address:

Position Held By Employee:

Work Hours for this Position:

Days of Worked for this Position:

A. ESSENTIAL FUNCTIONS OF JOB

B. PHYSICAL DEMANDS OF JOB

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II. TO BE COMPLETED BY EMPLOYEE:

Health Care Provider Name: _____

Health Care Provider Address: _____

_____

_____

Health Care Provider Telephone Number: _____

Health Care Provider Fax Number: _____

I authorize the health care provider identified above to provide to my employer, Conner Strong, including any of its employees and/or agents, the medical and other information requested in this Accommodation Assessment Form.

Employee Signature: _____ Date: _____

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III. TO BE COMPLETED BY HEALTH CARE PROVIDER:

A. NATURE OF EMPLOYEE'S CONDITION.[1]

1. Please describe the nature of the physical and/or mental condition(s) for which you are treating the Employee.

   _____

   _____

2. For how long have you been treating the Employee for the above-stated condition(s)?_____

3. Please indicate any limitations which result from the physical or mental condition(s) for which you are treating the Employee:

   _____

   _____

   _____

   _____

B. RESTRICTIONS ON ESSENTIAL FUNCTIONS AND PHYSICAL DEMANDS

1. Please state which, if any, of the essential functions or physical demands the Employee totally cannot perform and for how long you believe the Employee will be precluded from performing each such function and physical demand.

   _____

   _____

   _____

[1] ***The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.***

_____
_____

2. Please state which, if any, of the essential functions or physical demands the Employee can only partially perform. As to each such function or demand, please state what the Employee can and cannot do and for how long you believe the partial limitation will apply.

_____
_____
_____
_____

C. ACCOMMODATION/ADJUSTMENTS.

1. For each essential function and physical demand that you have indicated that the Employee cannot perform (either completely or partially), please let us know if there are any accommodations you would like Conner Strong to consider that would enable the Employee to perform the essential function or physical demand of the job.

   a. Accommodation Proposed:

   _____
   _____

      i. Essential Function/physical demand to which the Accommodation Relates:

      _____
      _____
      _____

      ii. How Long the Accommodation Will Be Necessary:

      _____
      _____
      _____

   b. Accommodation Proposed:

   _____
   _____

      i. Essential Function/physical demand to which the Accommodation Relates:

      _____
      _____
      _____

      ii. How Long the Accommodation Will Be Necessary:

      _____

_____
_____

c. Accommodation Proposed:

_____
_____

i. Essential Function/physical demand to which the Accommodation Relates:

_____
_____
_____

ii. How Long the Accommodation Will Be Necessary:

_____
_____
_____

Please attach additional pages as necessary if other accommodations are recommended for consideration. For each additional accommodation proposed, please answer same questions as above.

2. If there is any additional information you need from Conner Strong to answer any of the above questions or to provide suggestions, please indicate what additional information that you may need. Please be detailed:_____
_____
_____
_____
_____
_____

Health Care Professional's Name:_____

Health Care Professional's Title:_____

Health Care Professional's Signature:_____

Date:_____

Please return the completed form to HRLeave@connerstrong.com.

In seeking information about possible accommodations, Conner Strong has not reached any conclusion, one way or the other, whether the Employee's condition may constitute a disability under any federal, state or local law. Conner Strong also reserves the right to request additional information as well as to determine whether any proposed accommodation is reasonable and/or imposes an undue hardship.