

STATE OF NEW YORK – DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION
Notification of Agency Determination:

(To be completed by the *DRA* and returned to the employee)

Name of Employee:

Based on the information you provided, DOCCS is able to provide you with a reasonable accommodation of your disability, as follows:

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Please discuss this with your supervisor. A letter from the Office of Diversity Management confirming this decision will be sent to you within the next week once you accept the accommodation. If you have any questions, please call the *DRA*. The employee should retain a copy of this form, and return the original with his or her signature to be filed by the *DRA*.

I accept ____ / reject ____ the above reasonable accommodation.

Employee Signature:

Date:

Based on the information you provided, DOCCS is unable to provide you with a reasonable accommodation of your disability, as you requested on: _____.

We are denying your request for the following reasons:

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Signature of *DRA*:

Date:

If you have any questions, please call the *DRA*. The employee should retain a copy of this form. The original will be filed by the *DRA*.