Revised (7/11)
Form #2614B
COPY LOCALLY
AS NEEDED

STATE OF NEW YORK - DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

REQUEST FOR REASONABLE ACCOMMODATION

_____ Correctional Facility

Inmate's Name	DIN#	Date

INMATE'S REQUEST

I request reasonable accommodation to participate in the following program and/or service:

I am limited in my ability to (explain disability or limitation): _____

The accommodation requested is: _____

(Sign and forward to the Deputy Superintendent for Program Services) _____
Inmate's Signature

REC'D BY DSP

_____ (DSP Name) _____ (Signature) _____ Date

MEDICAL VERIFICATION

Disability _____

Functional limitations _____

No medical verification is on file. Follow-up appointment scheduled? ☐ yes ☐ no

Date inmate notified of pending medical evaluation/consult: _____

_____ (Medical staff name - title) _____ (Signature) _____ Date

REASONABLE ACCOM. DETERMINATION

The above requested reasonable accommodation has been: ☐ Approved ☐ Modified ☐ Denied

The specific accommodations approved are: _____

_____

Explanation of modification or denial: _____

_____

_____ (Inmate's Signature) _____ (DSP or designee signature) _____ Date

INMATE RECEIPT

☐ I agree ☐ I disagree with this determination.

I understand my right to file a grievance in accordance with Directive #4040, "Inmate Grievance Program"

Signature _____ Date _____

Original - Guidance Folder
Copies - Inmate, Superintendent, Medical, Parole, ADA Coordinator (Central Office)