REQUEST FOR RECONSIDERATION FORM

Date		
Name of individual requesting	reconsideration	
Address		
City	State	
Zip Code		
Email	Phone Number	-
	tion only if the request for reconsideration is being r than the individual who was denied an accommodation	;
Request for Reconsideration s	ubmitted on behalf of above-named individual by	
Name		
Title (if applicable)		_
		_
		_
	State	_
Zip Code	Email	
Phone Number		

1.	Name/Location of the Court or Court Facility in which the accommodation was sought
2.	Case name and number, if applicable:
3.	Accommodation requested:
4.	Basis for requesting reconsideration (If necessary, use additional paper to complete you statement. You may submit additional written material or documents relevant to your request.)

5.	State the desired remedy or the solution requested

The request for reconsideration must be submitted no later than 10 days after the date of the written Denial of Accommodation. Send the completed Request for Reconsideration form, with a copy of the Denial of Accommodation form, by email or mail to:

NY State ADA Coordinator NYS Unified Court System 25 Beaver Street, Suite 770 New York, New York 10004 (212) 428-2760

ada@nycourts.gov