



NEW JERSEY STATE EMPLOYEE SURVEY ON DISABILITIES

In cooperation with the Governor's Committee on the Disabled, we are actively working to ensure that persons with disabilities receive appropriate assistance in entering, remaining and advancing in State government.

Toward these goals, we are providing this survey for voluntary and confidential return to the Division of Equal Employment Opportunity and Affirmative Action. If you have any questions, you may contact the Division.

Thank you for your anticipated cooperation in our efforts to ensure an equitable workplace for all employees.

TO ALL STATE EMPLOYEES:

**PLEASE READ AND COMPLETE THIS SURVEY.
THEN RETURN AS DIRECTED ON PAGE 2.**

**DIVISION OF EQUAL EMPLOYMENT OPPORTUNITY AND AFFIRMATIVE ACTION
NEW JERSEY CIVIL SERVICE COMMISSION
PO BOX 315
TRENTON, NEW JERSEY 08625-0315**

INSTRUCTIONS

The State of New Jersey needs YOUR help to determine how affirmative action can be taken to better meet the needs of State employees with disabilities or handicaps which may affect their job. In order to accomplish this, we need information from ALL State government employees. Your participation in this survey will give our State government the necessary information to develop programs that will promote the hiring, advancement and retention of persons with disabilities. DO NOT write or type your name on this form. The information provided will be kept at the New Jersey Civil Service Commission and **will remain confidential**.

You do not have to provide any information on this survey if you do not wish to do so. However, we are required by State law to have affirmative action goals for the employment of persons with disabilities. Your social security number is requested on the survey in order to maintain statistics—numbers only, never names—on the progress New Jersey is making to ensure equal opportunity for persons with disabilities at all levels of government. Your social security number will be used to identify the agency for which you work and the general job category that you are in. Through the use of separate confidential files, your name will never be connected with this information.

Your voluntary cooperation in completing and returning this confidential survey will be appreciated.

HOW TO RETURN THIS FORM

To ensure confidentiality, DO NOT give this survey to your supervisor. Please send it directly to the New Jersey Civil Service Commission. When the form is completed, fold on the dotted lines, and **return by mail**. If you use the Inter-Office mail system, just staple this form closed, it will serve as your envelope. Otherwise, use a regular agency or blank envelope, seal the envelope, and return to the address found below, using the State postage system.

**Civil Service Commission
Division of Equal Employment Opportunity and Affirmative Action
Employee Survey On Disabilities
PO BOX 315
Trenton, New Jersey 08625-0315**

PLEASE RETURN AS SOON AS POSSIBLE

The information requested is authorized by the U.S. Rehabilitation Act of 1973 and N.J.S. 11A: 7-1 et seq.

New Jersey State Employee Survey On Disabilities

Civil Service Commission
Division of Equal Employment Opportunity and Affirmative Action
PO BOX 315
Trenton, New Jersey 08625-0315

Is this the first time you are completing the New Jersey Employee Survey on Disabilities?

YES NO

YOUR SOCIAL SECURITY NUMBER: - -

DATE:

1. DO YOU HAVE A DISABILITY?

- NO IF NO, PLEASE **STOP HERE** AND RETURN THIS SURVEY AS DIRECTED.
- YES IF YES, PLEASE CHECK ANY OF THE FOLLOWING WHICH APPLY TO YOU.

2. **BLINDNESS/VISUAL IMPAIRMENT** (such as blindness, blindness in one eye, uncorrectable restricted vision, etc.)
3. **DEAFNESS/HEARING IMPAIRMENT** (such as deafness, limited hearing, use of hearing aid, etc)
4. **ORTHOPEDIC DISABILITY** (such as limited use of limbs, one or more limbs missing; problems with hips, back, pelvis, or other bone structure, etc.)
5. **HEART OR CIRCULATION DISABILITY** (such as heart disease, stroke, hypertension, etc.)
6. **NEUROLOGICAL DISABILITY** (such as cerebral palsy, multiple sclerosis, mental retardation, learning disability, epilepsy, convulsions, etc.)
7. **RESPIRATORY DISABILITY** (such as tuberculosis, emphysema, asthma, etc.)
8. **SPEECH IMPAIRMENT** (such as inability to speak, or speak clearly)
9. **EMOTIONAL OR PSYCHIATRIC DISABILITY** (such as anxiety, nervous breakdown, depression, etc.)
10. **OTHER DISABILITIES** (such as diabetes, kidney problems, cancer, facial disfigurement, history of alcohol/drug abuse, immunodeficiency virus [HIV infection], etc.)

PLEASE SPECIFY: _____

IF YOU CHECKED ANY OF THE DISABILITY GROUPS ABOVE, ITEMS 2 TO 10 AND YOU NEED A JOB RELATED ACCOMMODATION FOR YOUR DISABILITY, YOU SHOULD FIRST CONTACT YOUR HUMAN RESOURCE OFFICE. IF YOU HAVE ANY QUESTIONS OR PROBLEMS WITH RECEIVING THE ACCOMMODATION, YOU SHOULD CONTACT YOUR EQUAL EMPLOYMENT OFFICER.

CUT ALONG THIS LINE BEFORE MAILING

Fold Line

Fold Line

**DO NOT WRITE OR TYPE
YOUR NAME OR ADDRESS**

State of New Jersey

INTEROFFICE MAIL

Civil Service Commission -- EEO/AA

Department

Division of Bureau

PO BOX 315

TRENTON, N.J. 08625-0315

Street Address or Name of Building

City

EMPLOYEE SURVEY ON DISABILITIES

CONFIDENTIAL

CONFIDENTIAL

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