**Workplace Accommodation Request Form**

Employees may request an accommodation of their work at any time. In order for the University to start the accommodation process, please provide the following information to assist in identifying potential solutions:

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| **Employee Name:** |  |
| **Department:** |  |
| **Job Title:** |  |
| **Contact Phone:**  |  |
| **Supervisor:**  |  |

1. Please describe the nature of your disability that has motivated your request for accommodation (i.e. mobility, visual, hearing, upper extremity, scheduling, psychological, etc.)

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1. For what duration will you require the accommodation?

– Temporary (please describe):

– Permanent (over 1 year)[[1]](#footnote-1)

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1. Is this request time sensitive? If yes, please explain.

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1. What specific areas of your work duties/job function/workplace are you experiencing barriers?

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1. What, if any, opportunities related to your employment are you having difficulty accessing (e.g. town hall meetings, extra-curricular/social activities, professional development opportunities, fitness facilities, amenities, career development, etc)?

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1. What limitation(s) is interfering with your ability to perform your job, or access an opportunity related to your employment?

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1. Do you have any concerns regarding your safety while attending your workplace? If yes, please explain.

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1. Do you require any accommodations/assistance in the event of an emergency (i.e. read /access emergency information, activation of our fire/security alarm system, using emergency exits, etc)?

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1. Have you received any accommodation in the past for a similar condition/situation? If yes, what were they and was it effective?

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1. Please provide any additional information that may be useful in processing your Accommodation request

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**\*\*Please note:** The University will work with each individual to provide a reasonable accommodation solution. It is your responsibility to participate in the accommodation process, including review of all reasonable, appropriate accommodation options. Your request may require the submission of identifiable, verifiable medical documentation indicating functional restrictions and limitations to Occupational Health to assist with identifying reasonable accommodation solutions.

By signing below, I agree to participate fully in the accommodation process, including review of all reasonable, appropriate accommodation options. I understand that information regarding my functional abilities, restrictions and/or limitations that result in modifications to my work may be shared with my manager, Human Resources, Safety Office, and/or relevant stakeholders/departments in order to implement reasonable accommodation solutions. I understand that medical information, if any, will be held in strict confidence within Occupational Health.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***If applicable:***

***I authorize Occupational Health to share this completed form to my treating practitioner, and for my practitioner to release verifiable medical information to Occupational Health in order to aid in developing an accommodation solution for my work at University of Waterloo***

*Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature Date*

Upon completion, please forward this form to Occupational Health at: occupationalhealth@uwaterloo.ca or Fax 519-888-4373

1. Permanent accommodations are subject to annual review of the effectiveness of accommodation solutions, which may include submission of updated information by any party [↑](#footnote-ref-1)