# Individual Accommodation Plan

Employee’s name:

Date:

Employee’s title/department:

Manager:

| **Limitations** |  **Job-related tasks/activities affected by limitations** | **Is this an essential job requirement?** |
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Sources of expert input into the individual accommodation plan (e.g., human resources manager, family doctor, specialists):

Accommodation measures are to be implemented from [start date] to [end date].

If no end date is expected, the next review of this accommodation plan will occur on [review date].

*(The accommodation measure(s) should be reviewed annually, at a minimum.)*

Description of Accommodation Measure(s)

| **Which job requirements and related tasks require accommodation?** | **What are the objectives of the accommodation (i.e., what must the accommodation do to be successful)?** | **Which accommodation strategies/tools have been selected to facilitate this task/activity?** |
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**Roles and Responsibilities**

| **Outstanding actions to implement accommodation** | **Assigned to** | **Due date** |
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**Additional Documents Included**

| **Document** | **Yes** | **No** |
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| Emergency Plan |  |  |
| Accessible Communications |  |  |
| Return-to-Work Plan  |  |  |

| Employee’s signature |  | Manager’s signature |
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