Individual Accommodation Plan ("IAP") / Return to Work Plan ("RWP")

Employee Name: _____

Job Title and Department: _____

Manager: _____

Date Accommodation Requested/Need Identified _____

Is the employee absent from work due to disability Yes No

If yes, date employee commenced disability-related leave_____ and expected date of return_____

Date/frequency of scheduled review(s) (if any) _____

Date employee is to provide updated medical information (if any) _____

Medical Information Provided

Date	Medical Professional	Medical Information Provided	Outstanding Questions/Additional Medical Information Required

Description of Limitations

Limitation	Job-Related Task/ Activity Affected by Limitation	Essential Requirement of the Job (Y/N)

Description of Accommodation Measures

Job-Related Task/ Activity Affected by Limitation (from Limitations section above)	**Accommodation Measure to Address Limitation (*e.g., modification to requirement, position, hours, duties and responsibilities, provision of assisted device, etc.)***	**Expected Duration of Accommodation Measure**

Roles and Responsibilities

Outstanding Actions to Implement Accommodation	**Assigned To**	**Due Date**

Related Documents (attach if applicable):

Individualized workplace emergency response information (if applicable)

Accessible Format of IAP/RWP (if applicable)

Other Information

_____

_____

_____

_____

_____

_____

_____

Employee's Signature _____

Date _____

Manager's Signature _____

Date _____