



**INDIVIDUAL ACCOMMODATION PLAN (IAP) FORM**

Note: This form is to be completed by the employee, in partnership with their supervisor/manager, with input as needed from Human Resources, healthcare professionals and/or subject matter expert(s).

For assistance please contact the HR Operations Assistant, Sarah Hugenholtz at: [shugholtz@yorkvilleu.ca](mailto:shugholtz@yorkvilleu.ca)

<b>Case Information</b>
<b>Name of Employee:</b>
<b>Gender pronouns (he/his, she/her, they/them, etc.) (Optional):</b>
<b>Position and Department/Program:</b>
<b>Contact information:</b>
<b><u>Accommodation Details</u></b>
Applicable human rights ground(s) that form the basis of the accommodation request: <input type="checkbox"/> Disability <input type="checkbox"/> Creed/Religion <input type="checkbox"/> Family status <input type="checkbox"/> Sex (including pregnancy and breastfeeding) <input type="checkbox"/> Gender identity and/or gender expression <input type="checkbox"/> Other human rights ground(s) (please specify):
Sources of Input (expert input, resources, and supports used in plan development): <input type="checkbox"/> Human Resources <input type="checkbox"/> Healthcare professional <input type="checkbox"/> Subject matter expert (please specify):
<b>Identified barriers:</b> Which job requirements and related tasks require an accommodation?
<b>Recommended accommodations:</b> What strategies, tools and/or technologies have been selected to remove barriers and facilitate the related task or activity?

**CONFIDENTIAL**

**Actions to implement accommodation (include interim accommodation actions if applicable):**

**Assigned to:**

**Date:**

**Follow-up Schedule**

If known, how long will the accommodations last?

Follow-up meetings will be scheduled: As needed Weekly Bi-weekly Monthly

If no end date is expected, the next review of this IAP will occur annually, unless both the employee and supervisor/manager agree that review is required sooner, or agree that in the case of a permanent accommodation, a scheduled review is no longer required.

Date of next annual review (as required):

**Agreement**

The goal of the Individual Accommodation Plan is to support the accommodation need by removing barriers and providing reasonable accommodations to support the employee in meeting the expectations of the job requirements.

The following parties have agreed to this plan (please sign and date):

Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Manager/Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

Plan Approved (if approval required):

Human Resources: \_\_\_\_\_ Date: \_\_\_\_\_