



Request for medical accommodation

If you need assistance in filling out this form, please contact your Union Representative, supervisor, or Work Life Consultant.

Section 1: Employee information

Employee Name (Surname, Given name(s):	Department:
Position title:	Date:

Section 2: Details of request

I am requesting a medical accommodation in my job due to: <i>Please describe your experience; diagnosis is not required</i>
Please outline your limitations, as you understand them:
What effect do these limitations have on your ability to do your job? Are there any specific duties in your job that you are unable to do?
What modifications to your work do you believe would assist you in remaining productive in your current position while managing your limitations?
Are you currently following a treatment plan for your medical condition? Please describe. <input type="checkbox"/> Yes <input type="checkbox"/> No
What is the expected duration of the requested accommodation?
Signature: Date:

Submit completed form to your supervisor. Request details will be shared with your assigned Work Life Consultant and your union representative, as needed, to evaluate and meet your needs. Please note: The employer will investigate the request and make every effort to offer a reasonable accommodation that also meets operational requirements. This may not necessarily be the exact accommodations requested.