REQUEST FOR MEDICAL ACCOMMODATION

DEPARTMENT Click here to enter text. DATE Click here to enter a date.

EMPLOYEE Click here to enter text. POSITION Click here to enter text.

If you would like assistance in filling out this form, please contact your Union Representative, Supervisor or [worklifeconsulting@uvic.ca](mailto:worklifeconsulting@uvic.ca).

I am requesting a medically based accommodation in my job due to (\*diagnosis not required):

Click here to enter text.

Please outline your limitations, as you understand them:

Click here to enter text.

What effect do these limitations have on your ability to do your job? Are there any duties in your job that you are unable to do?

Click here to enter text.

What modifications to your work do you believe would assist you in remaining productive in your current position while managing your limitations?

Click here to enter text.

Are you currently following a treatment plan for your medical condition? Yes No

Click here to enter text.

What is the expected duration of the requested accommodation?

Click here to enter text.

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| --- | --- | --- | --- |
| Signature: |  | Date: | Click here to enter a date. |

Please give this form to your supervisor who will send a copy to the assigned Work-Life Consultant, who may forward a copy to the Union Representative.