

In Accordance with CAFN Human Resources Manual 8.4  
Occupational Health and Safety

Name:	Title:
Department:	Date of Request:
Describe request or need to be addressed:	
Professional Assessment provided:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of person completing form:	
Signature of person completing form:	
Signature of person requesting accommodation:	
Clarification of Need:	
Estimated cost of accommodation (if applicable):	

\* If appropriate please attach supporting documentation.

### Report of outcome of accommodation request (to be completed by HR Department)

1. Was accommodation provided? (if no go to question 7)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. If yes, describe the accommodation provided:	
3. What was the dollar cost (if any) of this accommodation?	
Cost Centre/Expense coding:	
4. Is this accommodation usable only by the individual staff member? (e.g., a specific computer screen, approval of particular leave, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Was this accommodation requested by the Employee?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Date accommodation implemented (go to question 9):	

7. If the answer to question 1 was no, please provide the reasons that the accommodation was not provided:  
(please attach relevant additional material)

8. Who authorized the decision not to provide accommodation?

9. Has the Employee been advised of the outcome of the request?

Yes

No

10. Has the Employee been advised of his/her appeal and complaint rights?

Yes

No

11. Date the Employee was advised:

Name:

Signature:

Date of Completion: