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| **Request/Document Accommodation Plans**  **Applicant Information** | | | | | | |
| First Name | | | Last Name | | | |
| Single Name | | | | | | |
| Street Number | Street Name | | | | Suite/Unit Number | |
| City/Town | Province | | | | Postal Code | |
| Telephone Number | | | | Mobile Number | | |
| Are you an employee at Embark Student Corp.? Yes No | | | | | | |
| **If yes, please indicate your:**  Department | | Work Location: | | | | Work Email: |
| Job Title: | | Supervisor/Manager: | | | |  |

**Identifying the Accommodation Requirement\***

\*Please attach a letter if you require additional space

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| Is your request for accommodation linked to one or more protected/prohibited grounds in the Embark Student Corp.’s Accommodation Policy? | □Yes □ No |
| If yes, identify the protected/prohibited ground(s): | |
| □Creed | |
| □Disability | |
| □Family Status | |
| □Gender expression | |
| □Gender identity | |
| □Sex (including pregnancy and breast feeding) | |
| □Other prohibited ground | |
| 1. **If you are an Embark Student Corp.’s employee:**   What is the specific job duty/requirement you are unable to meet? | |

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| What is the barrier or restriction (functional limitation) that prevents you from meeting that job requirement? |
| **B. If you are receiving service from the Embark Student Corp.:**  What is the specific service or facility you are unable to access? |
| What is the barrier or restriction (functional limitation) that prevents you from accessing that service or location? |
| **C. If you are an Embark Student Corp. job applicant:**  What part of the job application process are you unable to fully participate in? |
| What is the barrier or restriction (functional limitation) that prevents you from fully participating in that part of the job application process? |

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| **Additional Information** | |
| Note that requests for accommodation are required to include sufficient information, including objective documentation, to confirm the need for accommodation and the type of accommodation required. Supporting documentation must be verifiable. Supporting documentation may not be required for those seeking accommodation on the grounds of gender identity and/or gender expression or creed. | |
| Signature | Date (yyyy-mm-dd) |
| **Office Use Only** | |
| Is there a link between the restrictions/functional limitations provided and a protected/prohibited  ground (creed, disability, family status, gender expression/identity, sex, etc.)? □Yes □ No  **If unsure, consult with the Human Resources** | |
| Have you reviewed the Accommodation Procedures? Guidelines for Accommodating Creed, Disabilities, Family Status, Gender Identity & Gender Expression, or Pregnancy &  Breastfeeding as applicable? □Yes □ No | |

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| Has the requester clearly identified their restrictions/functional limitations?  **If no, identify questions to ask the requester and/or seek expert input from the Human Resources as appropriate? Document questions and responses and attach to this form.** | | | | | □Yes □ No |
| Has the requester provided adequate information/documentation that supports the requester requires accommodation?  **If no, request supporting documentation and/or seek expert input** | | | | | □Yes □ No |
| Note details of who was contacted and what expert input was provided (e.g., Employee Health & Rehabilitation, medical specialists, Human Rights Office). Attach details of all expert input to this form | | | | | |
| **Restrictions/ Functional Limitations** | |  | | | |
| **What task(s) or service need(s) are impacted by the restrictions/limitations?** | |  | | | |
| **Is the task or service essential? What modification options would ensure the individual is able to perform the task or access the service?** | |  | | | |
| Is accommodation required?  If yes, contact the requester to discuss accommodation options. Continue to document the process including the steps identified below*.*  **If no, Consult with the Human Resources.** | | | | | □Yes □ No |
| **Description of Accommodation Measure(s):** | | | | | |
| Requirement(s) or task(s) requiring accommodation |  | |  |  | |

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| Objective of the accommodation |  | |  | |  |
| Accommodation strategies & tools to facilitate task(s) |  | |  | |  |
| Costs (if appropriate) |  | |  | |  |
| **Roles & Responsibilities:** | | | | | |
| Outstanding actions to implement accommodation | |  | |  | |
| Assigned to: (name/position) | |  | |  | |
| Due date (yyyy-mm-dd): | |  | |  | |
| **Timeline: Start Date** (yyyy-mm-dd) **End Date** (yyyy-mm-dd)  **Review Date** (yyyy-mm-dd) | | | | | |
| Is this plan prepared for an employee with a disability who requires workplace emergency  response information? □Yes □ No  If yes, indicate date when emergency response information provided to employee: | | | | | |
| If an employee, has the requester been provided with an individualized accommodation plan  and signed off on the plan? □Yes □ No | | | | | |
| Manager's Signature | | | | Date (yyyy-mm-dd) | |
| Requester's Signature | | | | Date (yyyy-mm-dd) | |