College of New Caledonia

WORKPLACE ACCOMMODATION APPLICATION FORM

The College of New Caledonia takes reasonable steps in accommodating potential, new and existing employees to the point of undue hardship. The information collected on this form will be used solely for the determination of accommodation needs and in ensuring a continued safe workplace. **Employees are responsible for any cost associated with the completion of this form.**

TO BE COMPLETED BY EMPLOYEE

For the purpose of determining my ability to safely perform my regular duties, I consent to the release of information to my employer and the following individuals:

Union Disability Management Representatives (*if applicable)*:______________________________

Employee Name: ______________________________ Department: ______________________________

Employee Signature: ______________________________ Date: ______________________________

TO BE COMPLETED BY A QUALIFIED MEDICAL PROFESSIONAL:

Based on the employee's medical diagnosis please review the employee's Job Description/Occupational Demand List and comment on the following questions without providing any medical diagnosis

Impact of the medical condition on the employee's ability to perform essential job duties:
Prognosis/projected duration of the medical condition:

Accommodation(s) required (please be specific with explanation):

- ❑ Reduced workload percentage or hours: ______________________________
- ❑ Schedule adjustments (i.e. Work start/end time): ______________________________
- ❑ Equipment needed: ______________________________
- ❑ Mobility restrictions: ______________________________
- ❑ Environmental restrictions: ______________________________
- ❑ Other: ______________________________

PHYSICIAN'S ASSESSMENT OF WORK ABILITIES: please indicate level of restrictions where applicable.

DEMAND	LIMITATIONS
Twist/Turn	
Bend	
Climb	
Walk	
Sit	
Squat	
Stand	
Balance	
Push / Pull	
Lift: Floor to waist Waist to shoulder Above shoulder	
Work Shifts	
Working at Heights	
Neck	
Shoulder	
Wrist	
Grip	
Judgment	
Ability to provide Supervision	
Ability to provide Instruction	
Public or Student Contact	
Multiple Tasks	
Concentration	
Hearing	
Speech	
Operating Machinery / Motor	
Other	

ESTIMATED DURATION OF RESTRICTION/INCAPACITY:	COMMENTS
❑ ______ days	
❑ 2 – 4 weeks	
❑ 4 – 6 weeks	
❑ 6 – 8 weeks	
❑ 8 – 10 weeks	
❑ > 10 weeks	
❑ long term ______weeks	
❑ Permanent.	

Treatment Plan/Appointment Schedule:

Additional Notes:

I certify that the information provided above is true and accurate to the best of my expertise and knowledge.

Professional's Name____

Professional's Preferred Contact Information: ____________________________

Professional's Signature ____________________________ Date: ___________

STAMP (if applicable)

RETURN COMPLETED FORM TO: HR@cnc.bc.ca or by Fax (250) 561 5864.

For HR use ONLY

❑ **Accommodation:**
Review Date ___________________________________

❑ **No Accommodation:**
Date Reason is provided _________________________

Any documentation of a personal or medical nature can be submitted to the Human Resources department, who will share (as required) only information related to any work-related restrictions or circumstances that require accommodation. The confidentiality of your personal and/or medical information will be safeguarded by the Human Resources department in accordance with FIPPA regulations.