Request for Reasonable Adjustment Plan - 2021

\*This information remains confidentially with Work Health Safety & Wellbeing until your disclosure wishes are discussed with the Staff Disability Advisor. Disclosure is your decision.

**Personal Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff Name** |  | | |
| **Staff ID #** |  | | |
| **Position** |  | | |
| **Staff Email** |  | | |
| **Gender** |  | | |
| **Home Phone No** |  | **Mobile No** |  |
| **Office Phone No** |  | | |

**Workplace Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Supervisor** |  | | |
| **Position** |  | | |
| **School/Division** |  | | |
| **Department/Unit** |  | | |
| **Home Campus** | ► | **Building/Room**: |  |
| **Other campus/es you regularly work on** | ► | **Building/Room**: |  |

**Medical Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Disability Type: (includes chronic medical condition)** | ► | | |
| **Additional Information** |  | | |
| **Do you have medical documentation, which:**   1. **is no more than 6 months old;** 2. **describes your disability or medical condition; and** 3. **recommends the types of workplace adjustments needed?** | **Y If yes, please submit with request form**  **N**  **If no, you will need to obtain medical documentation which is no more than 6 months old; describes your disability or medical condition; and recommends the types of workplace adjustments needed, before a Reasonable Adjustment Plan can be put in place.**  **This should be from a treating registered medical practitioner.** | | |
| **Medical Documentation Date:** | ► | | |
| **Treating Physician/Practices** |  | | |
| **Have Work Health & Safety staff undertaken a recent ergonomic assessment of your desk/workstation?** |  | | |
| **Are you currently:  attending work?** | **Y**  **N** | | |
| **on Sick Leave?** | **Y**  **N** | **Anticipated date of return, if applicable:** |  |
| **Other (please tell us anything else that you’d like us to know before we contact you)** |  | | |

**Reasonable Adjustments**

|  |  |
| --- | --- |
| **How does the condition or disability impact the way you work at Western?** |  |
| **What type/s of adjustment/s are you requesting the University put in place?** |  |
| **Is your supervisor aware of your medical condition/disability?** | **Y**  **N** |
| **Do you travel interstate or overseas in your role at Western?** | **Y**  **N** |
| **How did you become aware of the services we offer for Reasonable Adjustment at work?** |  |
| **Have you indicated that you have a disability/med condition on the EEO Survey on StaffOnline?** | **Y**  **N** |
| **Additional Information** |  |
| **Date Completed** |  |