|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** |  | | |
| **EMPLOYEE POSITION** |  | | |
| **SCHOOL/SECTION** |  | | |
| **DATE OF PLAN DEVELOPMENT** |  | | |
| **CO-ORDINATED BY** |  | | |
| **RTW GOAL (if applicable)** |  | | |
| **NORMAL DAYS** |  | **RTW PLAN DAYS (if applicable)** |  |

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| --- |
| **WORK RELATED IMPACTS of the illness, injury or disability.** |
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| --- | --- | --- | --- |
| **AGREED ADJUSTMENTS**  The University has assessed the following to be reasonable adjustments in accommodating reported condition(s) and agrees to implement and maintain these items in order to overcome any work related impacts. The following will be implemented and maintained unless to continue with an item would cause an unjustifiable hardship for the University, at which time the reasonable adjustments will be reviewed. | **START DATE** | **END DATE (if temporary)** | **REVIEW DATE/S** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **EMPLOYEE SIGN OFF** | I agree with this workplace adjustment plan and that this plan will be accessible to relevant Human Resources staff and my supervisor | | |
| **SIGNATURE** |  | **DATE** |  |

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| --- | --- | --- | --- |
| **SUPERVISOR SIGN OFF** | I agree to support this Reasonable Adjustment Plan | | |
| **SIGNATURE** |  | **DATE** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **TREATING HEALTH PRACTITIONER SIGN OFF (if applicable)** | I agree to support this Reasonable Adjustment Plan | | |
| **SIGNATURE** |  | **DATE** |  |