



# Sample Individual Accommodation Plan (IAP) for Trucking and Logistics Industry Employers

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## ACCESSIBILITY FOR ONTARIANS WITH DISABILITIES ACT

This resource references *Accessibility for Ontarians with Disabilities Act*. This Ontario based legislation outlines accessibility standards that came into effect in 2005. They are comprehensive and employers who follow them will likely be compliant with similar legislation from other provinces however consult your own provincial standards to confirm your legislative requirements. Employers not governed by the *Accessibility for Ontarians with Disabilities Act* or other legislation, who choose to adopt the principles of this legislation will lead the market in their employment practices for persons with disabilities.



**Note** – while this process is recommended for all, organizations with 50+ employees are required under *Accessibility for Ontarians with Disabilities Act* to develop and have in place a written process for the development of documented individual accommodation plans for employees with disabilities.

**Instructions:** This form is intended to formally document the employee’s accommodation requirements, accommodation options and decided actions discussed and agreed to as part of [Company Name]’s accommodation process. In collaboration, the supervisor/ manager and the employee (and representative if requested by the employee), should complete the information below.

## PART 1 – EMPLOYEE INFORMATION

Employee Name: \_\_\_\_\_ Department: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Current Position: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Current Manager: \_\_\_\_\_

Work Location: \_\_\_\_\_

### Type of Disability

Temporary       Permanent

### Work Type

Driver       Office       Shop       Warehouse



## PART 2 – THE IAP PARTICIPANTS

List the participants involved in the creation and implementation of the IAP including the employee, supervisor, third party consultants, representatives, and medical specialist, as applicable.

Name:	Title/Role
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Additional Documentation Provided by Participants**  
*(e.g. Functional Abilities form, emergency plan, medical notes)*

Name of Document:	Provided By:	Attached
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>



**PART 3 - DETAILS OF THE INDIVIDUAL ACCOMMODATION**

**Restrictions/Limitations:**

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**Specific position-related tasks affected by limitations:**

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**Potential strategies/ tools / equipment required for accommodation?**

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**Accommodation measures implemented:**

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Are accessible formats or communication supports required by the employee? Yes  No

**If yes, indicate the accessible formats/communication supports that will be provided:**

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Has individual accessible workplace emergency response information been provided to employee? Yes  No

Does the employee require assistance during an emergency in the workplace? Yes  No

If yes, and with employees' consent, has a designate representative been assigned? Yes  No



## PART 4 – IMPLEMENTATION AND REVIEW DATES

Accommodation measures are in place from: \_\_\_\_\_ [date] to: \_\_\_\_\_ [date]

If no end date is expected this IAP will be reviewed:

Quarterly

Annually

Bi-annually

Other \_\_\_\_\_

## PART 5 – SIGNATURES

This Individual Accommodation Plan has been developed in consultation with all stakeholders to ensure that the needs of both the employee and [Company Name] are met throughout the accommodation process.

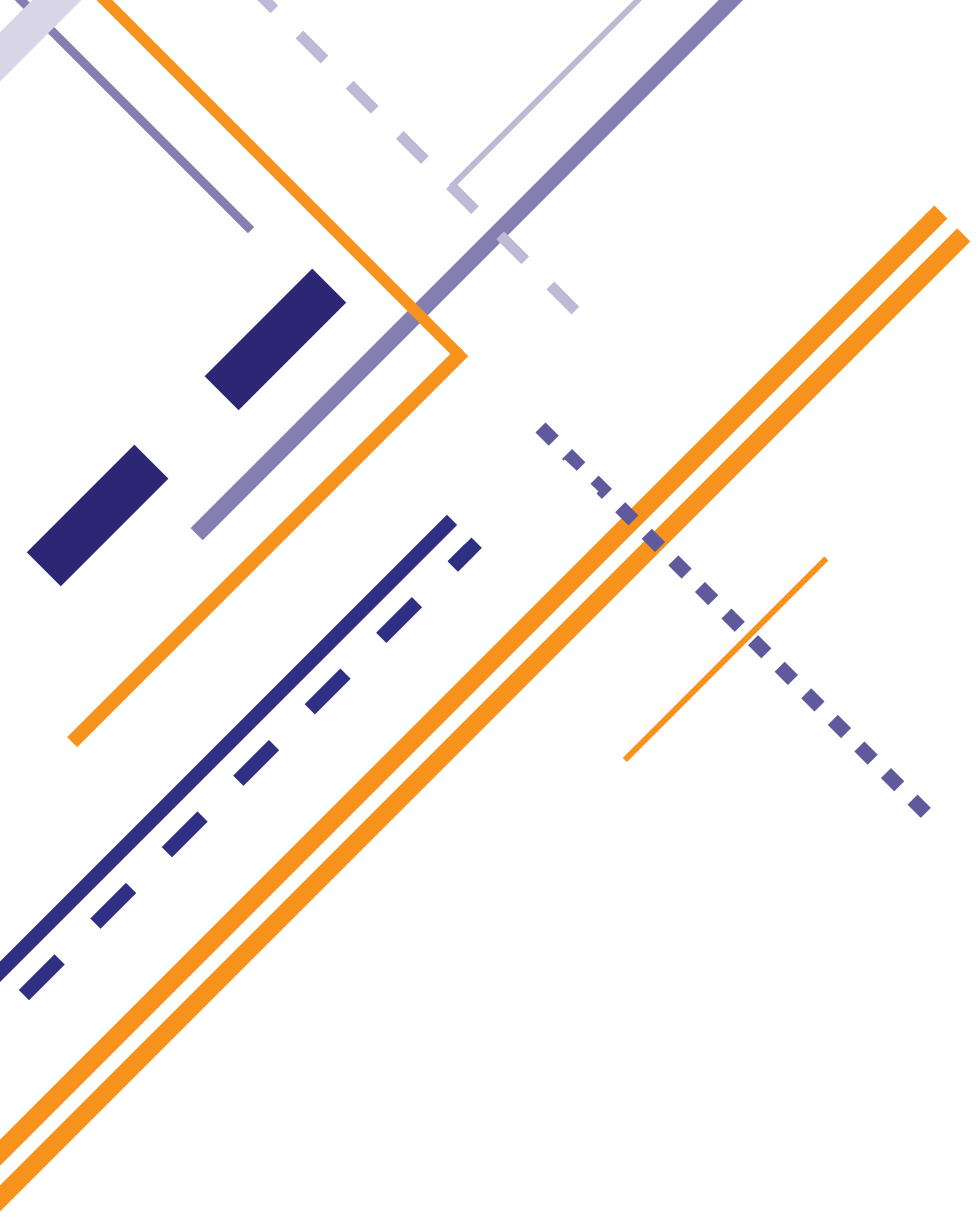
\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervisor/Manager

\_\_\_\_\_  
Date





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**FUNDING PROVIDED BY:**

