TruckingHR Canada

Individual Accommodation Plan (IAP) – Sample

June 2025

ABOUT TRUCKING HR CANADA

As a national, non-profit organization, Trucking HR Canada advances modern HR solutions for the trucking and logistics workforce. One of our strategic priorities is to make a company's job easier by delivering a comprehensive collection of up-to-date guides, reports, templates and more to support effective human resource management, recruitment, and retention efforts.

Visit truckinghr.com to find out more.

DISCLAIMER

The information contained within does not constitute legal advice. Trucking HR Canada, and all content contributors, bear no responsibility for any circumstances arising out of or related to the adoption, or decision not to adopt, any of the recommendations contained in this document.

WANT MORE?

Visit the **HR Resource Library** on Trucking HR Canada's website for up to date, practical HR management guides and tools designed specifically for trucking and logistics employers.

THE LEGISLATIVE CONTEXT

This resource reflects the *Accessibility for Ontarians with Disabilities Act (AODA)* as well as federal requirements related to accessibility and accommodation. The tool will likely be compliant with similar legislation from other jurisdictions; however, consult your own provincial or territorial standards to confirm the specifics of your legislative requirements.

In any jurisdiction, employers who consistently put these principles into practice will lead the market in their employment practices for persons with disabilities.

Provincially Regulated in Ontario: Companies with 50+ employees are required under *Accessibility for Ontarians with Disabilities Act* to have a written process for the development of documented individual accommodation plans for employees with disabilities.

Individual Accommodation Plan (IAP) – A Sample

Instructions: Use this form to document the employee's accommodation requirements, accommodation options and the actions agreed to as part of [*Company Name*]'s accommodation process. The supervisor/ manager and the employee (and representative if requested by the employee), should jointly complete the information below.

PART 1 – EMPLOYEE INFORMATION

Employee Name: _____ Department: _____

Home Phone #: _____ Current Position: _____

Cell Phone #: _____ Current Manager: _____

Work Location: _____

Type of Limitation* (check all that apply)

☐ Temporary ☐ Chronic ☐ Persistent ☐ Episodic

* **Temporary:** any limitation that may resolve with time (e.g., acute stress disorder, traumatic brain injury, recovery from surgery)
Chronic: any life-long limitation that does not resolve with time (e.g., diabetes, fibromyalgia, bipolar disorder)
Persistent: any limitation with symptoms that are almost always present (e.g., Parkinson's, visual impairment, OCD)
Episodic: any limitation with fluctuating periods of wellness and symptom presence (e.g., asthma, epilepsy, PTSD)

Work Type (check all that apply)

☐ Driver ☐ Office ☐ Shop ☐ Warehouse

PART 2 – THE IAP PARTICIPANTS

List the participants involved in creating and implementing the IAP. Include 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
		☐
		☐
		☐

PART 3 - DETAILS OF THE INDIVIDUAL ACCOMMODATION

Restrictions/Limitations:

Specific position-related tasks affected by limitations:

Potential strategies / tools / equipment required for accommodation:

Will training be required on any new or adjusted work methods, tools or equipment? Yes ☐ No ☐

If yes, indicate the nature and timing of learning support that will be provided:

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

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

Accommodation measures implemented:

Has individual accessible workplace emergency response information been provided to the employee?	Yes ☐	No ☐
Does the employee require assistance during an emergency in the workplace?	Yes ☐	No ☐
If yes, and with employees' consent, has a designated representative been assigned?	Yes ☐	No ☐

PART 4 – IMPLEMENTATION AND REVIEW DATES

Accommodation measures are in place from: _____ [*date*] to: _____ [*date*]

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

☐ Quarterly

☐ Semi-annually

☐ Annually

☐ Other _____

Questions or concerns about this accommodation plan can be addressed to:

Name: Title/Role

_____ _____

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