WORKPLACE ADJUSTMENT MANAGEMENT PLAN

Workplace Adjustment Management Plan No:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

STAFF MEMBER

Surname:	**Given Name**:
Date of notification:	**Position held:**
Description of disability:	

UNIVERSITY CONTACT	**NOMINATED TREATING DOCTOR**
Contact Person: Name and position of contact person responsible for completing this form in collaboration with the staff member	**Name** : Dr **Telephone** :

OTHER TREATMENT PROVIDERS	**OTHER TREATMENT PROVIDERS**
Name:	Name:
Telephone:	Telephone:

BACKGROUND INFORMATION

WORKPLACE ADJUSTMENT PLAN

Service/Action	Person Responsible	Review Date
1. Assessment		
2. Recommendations		
3. Approval		
4. Implementation		
5. Three month review		
6. Annual review (if required)		

MEDICAL INFORMATION

Medical evidence of disability has been provided ☐ Yes ☐ No

Medical assessment has been requested by the University ☐ Yes ☐ No

Medical Evidence	Medical practitioner	Date

The person is able to complete the inherent requirements of the position ☐ Yes ☐ No

Adjustment to position requirements	Person Responsible	Review date if not permanent

COMMENTS AND ISSUES

SIGNED

Coordinator of the Workplace Adjustment Management Plan: Date: / /

Staff member:

Note: A copy of this will be kept with your Personnel File Date : / /

Supervisor of staff member: Date : / /

REVIEW DATE

This plan will be reviewed on Date: / / **REVIEWED** Date : / /

Comments:

This plan will be reviewed on Date: / / **REVIEWED** Date : / /

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