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| --- |
| **Medical Duty to Accommodate letter** |

Enter date.

Enter employee’s name

Enter employee’s address

Re: Confirmation of Medical Duty to Accommodate Agreement

Dear Enter name

This letter is to confirm the Medical Duty to Accommodate Agreement reached between you and Enter organization based on the medical assessment received by your health care provider on Enter a date.

The terms of this agreement are outlined below:

|  |  |  |
| --- | --- | --- |
| **EMPLOYMENT DETAILS (pre-medical duty to accommodate agreement)** | | |
| Department/Program: |  | |
| Position: |  | |
| FTE/Bi-weekly hours: |  | |
| **RESTRICTIONS REQUIRING ACCOMODATION** | | |
| *[Insert list of limitations]* | | |
| **TERMS OF AGREEMENT** | | |
| Start date: Enter a date. | | Expected end date: Enter a date. |
| Description of the modifications: | | |

This Medical Duty to Accommodate Agreement does not abrogate [Organization]’s right to review the terms of this Agreement at any time in relation to operational needs, policy, and/or plan changes, or due to changes in your personal circumstances. You acknowledge that the terms and conditions of your employment may be adjusted accordingly. Nothing in this Agreement supersedes the principles of just cause or the duty to accommodate.

Should you have any questions regarding your accommodation, please feel free to contact me at Enter contact information.

Sincerely,

Enter name

Enter title

Enter organization name

Enter contact information

To confirm your agreement with the terms of the Medical Duty to Accommodate Agreement as outlined above, please sign in the appropriate space below:

|  |  |
| --- | --- |
| **X** |  |
| **Employee signature** | **Date** |
| **X** |  |
| **Supervisor signature** | **Date** |
| **X** |  |
| **HR department signature** | **Date** |