# AODA INTEGRATED ACCESSIBILITY STANDARD

## INDIVIDUALIZED EMPLOYEE ACCOMMODATION PROCEDURE

made pursuant to the provisions of the **Accessibility for Ontarians with Disabilities Act, 2005**, S.O. 2005, c. 11 (hereinafter the AODA"). This Individualized Employee Accommodation Procedure is © Cohen Highley LLP, 2013. Please note that this Individualized Employee Accommodation Procedure is for the use of Cohen Highley LLP and the Lawyers Resource Centre Limited Partnership (hereinafter collectively referred to as "CH").

Cohen Highley LLP and the Lawyers Resource Centre Limited Partnership (hereinafter collectively referred to as "CH") are committed to providing a safe, respectful, welcoming and inclusive environment in which all employees can reach their full potential. The following Individualized Employee Accommodation Procedure (the "Procedure") has been developed in accordance with the *Accessibility for Ontarians with Disabilities Act, 2005*, S.O. 2005, c. 11 (the "AODA"), Ontario Regulation 191/11 (the "Integrated Accessibility Standard"), and is guided by the fundamental principles underlying the AODA.

### 1. Objectives

The objective of this Procedure is to provide a framework through which CH can provide accommodation to employees with disabilities, including providing accommodation during a workplace emergency.

### 2. Barriers to Employment

CH provides accommodation to employees that encounter barriers to employment because of a disability up to the point of undue hardship. These barriers may include anything that prevents a person with a disability from fully participating in all aspects of their employment because of his or her disability; including a physical barrier, an architectural barrier, an information or communications barrier, an attitudinal barrier, a technological barrier, a policy or a practice.

### 3. Individual Assessment Form

The Individual Assessment Form asks the Employee to think about various job-related tasks/activities and situations that may arise during their employment. It is intended to help identify barriers that could arise in the workplace or during an emergency situation. The Employee has an opportunity to provide suggestions on how to overcome these potential barriers. The Employee's input is intended to help CH provide the Employee with appropriate accommodation and with individualized emergency information.

#### 3.01 Completion of Individual Assessment at the Start of Employment

As soon as practicable after starting work at CH, all employees will be asked to complete an Individual Assessment Form (attached as **Schedule "A"**).

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### 3.02 Completion of Individual Assessment Form During Employment

CH recognizes that an Employee may have a need for accommodation during their employment. When an Employee believes that he or she may need accommodation (whether permanent or temporary), the Employee is required to complete an Individual Assessment Form as soon as practicable. Where the Employee is perceived to be unwell or in need of accommodation, CH may also initiate a dialogue with the Employee to determine if accommodation in the workplace may be necessary.

## 4. Review Individual Assessment Form

When the Individual Assessment Form is complete, the Employee should provide the Individual Assessment Form to the Human Resources Manager (Sue Mahoney). As soon as practicable after receiving the Individual Assessment Form, the Human Resources Manager will review the Individual Assessment Form.

### 4.01 Where Accommodation is Not Required

Where accommodation is not required, the Human Resources Manager shall keep the Individual Assessment Form in the Employee's confidential personnel file.

### 4.02 Where Accommodation May be Required

Where accommodation may be required, the Employee will be asked to work with the Human Resources Manager and the AODA Compliance Officer to develop an Individualized Employee Accommodation Plan (referred to as the "Accommodation Plan" and attached as **Schedule "B"**). As part of the Accommodation Plan, an Individualized Workplace Emergency Response Plan (referred to as the "Workplace Emergency Plan" and attached as **Schedule "C"**) may also be required.

## 5. Participation of Third Parties

CH does not require details on the nature of the Employee's disability to provide an accommodation; however, CH does need to know about the Employee's functional abilities and limitations and CH may request medical documentation from the Employee's family doctor and/or health care provider.

### 5.01 CH Request for Participation of Third Parties

In order to properly complete the Individual Assessment Form, the Accommodation Plan, and/or the Workplace Emergency Plan, the Human Resources Manager and the AODA Compliance Officer may also request an evaluation by an outside medical or other expert, at CH's expense, to determine if and how accommodation can be achieved.

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### 5.02 Employee Request for Participation of Third Parties

The Employee may wish to have a representative from CH become involved in the completion of the Individual Assessment Form, the Accommodation Plan, and/or the Workplace Emergency Plan (i.e. the Employee's Department Head).

If the Employee wishes to involve a representative from CH, the Employee should provide the request to the Human Resources Manager and/or the AODA Compliance Officer in writing or in an alternative format that takes into account the Employee's disability.

## 6. Individualized Employee Accommodation Plan

The Accommodation Plan is designed to identify the most appropriate accommodation for the Employee. The Accommodation Plan shall be developed in consultation with the Employee, the Human Resources Manager, the AODA Compliance Officer and any other individuals that are determined to be necessary or appropriate.

### 6.01 Individualized Workplace Emergency Response Plan

If required, the Workplace Emergency Plan shall form part of the Accommodation Plan and shall be in the form attached at Schedule "C". The Workplace Emergency Plan is designed to provide emergency response information that is tailored to the Employee's needs if the Employee's disability requires it.

## 7. Approval, Amendment or Denial of Accommodation Plan

Once complete, the Accommodation Plan shall be provided to CH's Management Committee. The Management Committee shall decide whether to approve, amend or deny the Accommodation Plan.

### 7.01 Evaluation by Expert

Prior to deciding whether to approve, amend, or deny the Accommodation Plan (including the Workplace Emergency Plan), the Management Committee may request an evaluation by an outside medical or other expert, at CH's expense.

### 7.02 Procedure Where Accommodation Plan is Approved

The Employee shall be provided with a copy of the approved Accommodation Plan in a format that takes into account his or her accessibility needs due to his or her disability.

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### 7.03 Procedure Where Accommodation Plan is Amended or Denied

If the Accommodation Plan is amended or denied by the Management Committee, CH shall provide the Employee with notice of the decision and the reasons for the decision. Notice shall be provided to the Employee in writing or in an alternative format that takes into account the Employee's disability.

The Employee shall be given ten (10) business days to provide a response to CH's decision in writing or in an alternative format that takes into account the Employee's disability. CH shall consider the Employee's response and shall provide the Employee with notice of CH's final decision in writing or in an alternative format that takes into account the Employee's disability.

## 8. Review and Update of the Accommodation Plan and/or the Workplace Emergency Plan

The Accommodation Plan and/or the Workplace Emergency Plan shall be reviewed with the Employee at least annually. In addition, the Human Resources Manager shall review the Accommodation Plan and/or the Workplace Emergency Plan with the Employee in the following circumstances:

(a) if the Employee's work location or position changes;
(b) if the nature of the Employee's disability changes;
(c) if CH makes changes to this Procedure; or
(d) when CH reviews its general emergency response policies.

### 8.01 Where Accommodation Plan is no longer Appropriate

If the accommodation set out in the Accommodation Plan is no longer appropriate, the Employee shall notify the Human Resources Manager as soon as practicable and complete a new Individual Assessment Form. Where workplace accommodation is required, the Employee will be asked to work with the Human Resources Manager and the AODA Compliance Officer to develop a new Accommodation Plan and/or a Workplace Emergency Plan pursuant to this Procedure.

## 9. Return to Work Process

Where an Employee has been absent from work due to a disability and require disability-related accommodation in order to return to work, the Employee is required to complete an Individual Assessment Form as soon as practicable (**Schedule "A"**).

### 9.01 Where Accommodation is Not Required

Where accommodation is not required, the Human Resources Manager shall keep the Individual Assessment Form in the Employee's confidential personnel file.

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### 9.02 Where Accommodation May be Required

Where workplace accommodation may be required, the Employee will be asked to work with the Human Resources Manager and the AODA Compliance Officer to develop a Return to Work Plan (**Schedule "D"**), which may include a Workplace Emergency Plan.

If appropriate, the Employee will be asked to work with the Human Resources Manager and the AODA Compliance Officer to develop an Accommodation Plan instead of a Return to Work Plan, which may include a Workplace Emergency Plan.

### 9.03 Approval of Return to Work Plan

Once complete, the Return to Work Plan shall be provided to CH's Management Committee. The Management Committee shall decide whether to approve, amend or deny the Return to Work Plan using the procedure outlined above for the Accommodation Plan.

## 10. Confidentiality

CH believes that individuals must be accommodated in ways that respect their dignity, worth, and right to privacy in the workplace. As such, all information contained in the Individual Assessment Form, the Accommodation Plan, the Workplace Emergency Plan, the Return to Work Plan and any other information relating to specific requests for accommodation will be treated as confidential and will not be shared without the Employee's knowledge and consent.

## 11. Accessible Formats and Communications Supports

If requested, CH will provide this Procedure and any other document referred to in the procedure in an accessible format or shall provide or arrange for the provision of appropriate communications supports.

## 12. Effective Date

This Procedure becomes effective January 1, 2016. It replaces and supercedes the AODA Workplace Emergency Response Policy, Version 1-2012.

## 13. Additional Obligations

CH recognizes that the AODA does not replace or supersede CH's obligations under the *Human Rights Code*, R.S.O. 1990, c. H.19 or the *Occupational Health and Safety Act,* R.S.O. 1990, c. O.1.

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## SCHEDULE "A" – INDIVIDUAL ASSESSMENT FORM

We ask that you complete this Individual Assessment Form to help us identify barriers and provide suggestions on how to overcome them. Your input will help us provide appropriate accommodations and individualized workplace emergency information. Please attach additional sheets as needed.

The personal information you disclose on this form is confidential and will only be shared with your consent.

Name: _____ Date: _____

Department: _____ Direct Supervisor: _____

### Part 1 – Need for Accommodation

**Do you believe that your job-related tasks/activities <u>may</u> be affected by any barriers? □ Yes □ No**

**IF NO,** please sign here and return this form to the Human Resources Manager: _____

**IF YES,** please complete Parts 2, 3, 4 and 5 below and return this form to the Human Resources Manager.

**IF YOU CHECKED "NO", YOU DO NOT NEED TO COMPLETE PARTS 2, 3, 4 AND 5 BELOW.**

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### Part 2 – Background Information

1. Describe any barriers which may affect your ability to complete job-related tasks/activities (for example: mobility, difficulties with reading, writing, numbers, spatial orientation, oral communication, memory, following directions, maintaining attention, concentration):

2. Are you taking medication that may impact on your ability to complete job-related tasks/activities? If yes, describe the impact of the medication on your ability to complete job-related tasks/activities:

3. Were you given specific accommodations during school, post-secondary studies, or previous jobs? If so, please describe:

4. Do you make use of any assistive devices? Please describe each assistive device and any barriers in your ability to use the assistive device at CH:

SAMPLE

## Part 3 – Potential Workplace Accommodations

5. What accommodations do you feel would meet your needs in ability to complete job-related tasks/activities? Please provide as much detail as possible and use extra pages if necessary.

6. Are there any assistive devices that you believe may assist in your ability to complete job-related tasks/activities? Please describe each assistive device.

7. Do you wish for another representative from CH to be involved in developing the Accommodation Plan and/or Workplace Emergency Plan? If so, who would you like to be involved in this process?

8. Please add any other relevant information:

## Part 4 – Potential Emergency Response Barriers

Please identify if you believe that any of the following emergency response features will provide a barrier to your safe evacuation of the building during a workplace emergency.

Where you know that there is a barrier, please identify any actions that CH can take during a workplace emergency, assistive devices, or any alternative measures that you believe may provide an accommodation.

Where you are unsure if there is a barrier, please identify how we can determine whether or not there is a barrier (i.e. practice an evacuation of the office).

| | | | |
|---|---|---|---|
| 1. The fire/security alarm signal | ☐ Yes | ☐ No | ☐ I don't know |
| 2. Communication with emergency staff | ☐ Yes | ☐ No | ☐ I don't know |
| 3. Emergency exits | ☐ Yes | ☐ No | ☐ I don't know |
| 4. Emergency waiting area (i.e. outside building) | ☐ Yes | ☐ No | ☐ I don't know |
| 5. Finding the exit in smoky or dark conditions | ☐ Yes | ☐ No | ☐ I don't know |

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6. Evacuation in a stressful and crowded situation ☐ Yes ☐ No ☐ I don't know

7. Reading/accessing our emergency information ☐ Yes ☐ No ☐ I don't know

8. If you need help to evacuate, what instructions do people need to help you?

_____

_____

_____

9. If you believe that you may need other accommodations in an emergency, please list them here.

_____

_____

_____

10. Please list any other comments or concerns:

_____

_____

_____

_____

_____

**Part 5 – Consent to Release of Information**

I, _____ [Employee's name], consent and authorize _____ [name of family doctor or health care provider] release information on my disability and functional abilities/limitations to my employer, Cohen Highley LLP and/or Lawyers Resource Centre Limited Partnership. This information will be used for the express purpose of determining appropriate accommodations for my employment.

Employee date of birth: _____ *(This is usually required by the professional office)*

Family Doctor/Health Care Provider's phone number: _____

Family Doctor/Health Care Provider's fax number: _____

Family Doctor/Health Care Provider's address: _____

Signature: _____ Date: _____

SAMPLE

## SCHEDULE "B" – INDIVUDALIZED EMPLOYEE ACCOMMODATION PLAN FOR

_____

Name: _____ Date: _____

Department: _____ Direct Supervisor: _____

Office Location: _____ Individual Assessment Form Completed? Y N

**Description of Barriers Identified:**

The following barriers and impacts on job-related tasks/activities have been identified *(attach additional pages if required)*:

| Barriers Identified | Job-related tasks/activities affected | Is this an essential job requirement? |
|---|---|---|
| | | |
| | | |
| | | |

**Implementation of Individualized Employee Accommodation Plan:**

The following strategies/tools have been designated to undertake the following tasks to implement this Individualized Employee Accommodation Plan *(attach additional pages if required)*:

| Which job requirements and related tasks require accommodation? | What are the objectives of the accommodation (i.e. what must the accommodation do to be successful?) | What accommodation strategies/tools have been selected to facilitate this task/activity |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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Sources of expert input into this Individual Accommodation Plan (i.e. family doctor, specialists):

_____

_____

_____

**Roles and Responsibilities:**
The following outstanding actions have been indentified to implement this Individualized Employee Accommodation Plan *(attach additional pages if required)*:

| Outstanding Actions to Implement Accommodation Plan | Person Responsible | Due Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Consent to Disclose this Individualized Employee Accommodation Plan**

I, _____, consent to Cohen Highley LLP sharing this Individualized Employee Accommodation Plan with the Management Committee and, if necessary, the individuals listed above who have been designated to be responsible for taking steps to implement this accommodation plan.

Signature:_____ Date:_____

**Review and Update of Individualized Employee Accommodation Plan**

Accommodation measures are to be implemented from _____ [start date] to _____ [end date].

If no end date is expected, the next review of this accommodation plan will occur on _____ __ [review date].
*(Please note: the accommodation measure(s) should be reviewed annually, at a minimum.)*

Employee Signature:_____ Human Resources Manager Signature:_____

Management Committee Approval:_____ Date:_____

SAMPLE

## SCHEDULE "C" – WORKPLACE EMERGENCY RESPONSE PLAN FOR:

_____

Name: _____ Date: _____

Department: _____ Direct Supervisor: _____

Office: _____ Workspace Location: _____

*Note: A Workplace Emergency Response Plan will need to be completed for each office (i.e. London and Kitchener)*

**Emergency Contact Person:**

Name: _____ Phone Number: _____

Email: _____ Relationship: _____

Address: _____
(Unit No.) (Address) (City) (Province) (Postal Code)

**Emergency Alerts:**

_____ will be informed of an emergency situation by:

- ☐ Fire/security alarm signal
- ☐ Visual alarm system
- ☐ Co-worker: _____
- ☐ Other (Specify): _____

**Assistance Methods:**

List types of assistance (e.g. staff assistance, etc.):

_____

_____

_____

**Equipment Required:**

List any devices required, where they are stored, and how to use them:

_____

_____

_____

SAMPLE

**Evacuation Route and/or Procedure:**

Provide a step-by-step description of the evacuation route and/or procedure. This should begin from the first sign of an emergency. Attach any additional sheets or drawings.

**Alternate Evacuation Route:**

**Emergency Support Staff:**

The following people have been designated to help the Employee in an emergency:

| Name | Description of Assistance | Alternative Staff to Provide Assistance |
|---|---|---|
| | | |
| | | |
| | | |

**Consent to share this Individualized Workplace Emergency Response Plan**

I, _____, consent to Cohen Highley LLP sharing this Individualized Workplace Emergency Response Plan with the Management Committee and, if necessary, the individuals listed above who have been designated to help me in an emergency.

Signature:_____ Date:_____

**Review and Update of Individualized Workplace Emergency Response Plan**

CH shall review the Individualized Employee Accommodation Plan with the Employee at the following times:

- When the Employee moves to a different location in the organization;
- When the Employee's Individualized Employee Accommodation Plan is reviewed; and,
- When CH reviews its general emergency response policies.

Employee Signature:_____ Human Resources Manager Signature:_____

Management Committee Approval:_____ Date:_____

SAMPLE

## SCHEDULE "D" – RETURN TO WORK PLAN FOR

_____

Department: _____ Direct Supervisor: _____

Office Location: _____ Individual Assessment Form Completed? Y N

**Goal of Return to Work Process: _____**

**Summary of Return to Work Process** *(attach additional pages if required)*:

| | Functional Limitations | Workdays per Week | Work Hours per Week | Job Tasks | Accommodation Provided |
|---|---|---|---|---|---|
| Week 1 | | | | | |
| Week 2 | | | | | |
| Week 3 | | | | | |
| Week 4 | | | | | |

Does the Return to Work Plan involve a temporary assignment to a different position? Y N

If yes, what is the new position? _____

Is training required? Y N What is the length of the assignment (if known)?_____

List any safety considerations and the safety precautions being taken:_____

_____

**Consent to Disclose this Return to Work Plan**

I, _____, consent to Cohen Highley LLP sharing this Return to Work Plan with the Management Committee and, if necessary, the individuals listed above who have been designated to be responsible for taking steps to implement this Return to Work Plan.

Signature:_____ Date:_____

**Review and Update of Individualized Employee Accommodation Plan**

This Return to Work Process is expected to be implemented from _____ [start date] to _____ [end date].
If no end date is expected, the next review of this accommodation plan will occur on _____ [review date].

*(Please note: the accommodation measure(s) should be reviewed annually, at a minimum.)*

Employee Signature:_____ Human Resources Manager Signature:_____

Management Committee Approval:_____ Date:_____

SAMPLE