Use this form to document workplace adjustments required to reduce or eliminate barriers at work arising from disability.

Information captured in this form is personal and sensitive and will be handed in accordance with UniSA’s [Privacy Policy](https://i.unisa.edu.au/policies-and-procedures/university-policies/hr/privacy-policy/). Copies to be retained by staff member and line manager.

|  |  |  |  |  |  |
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| **SECTION 1: STAFF MEMBER DETAILS** | | | | | |
| **Full Name** |  | **Position** | |  | |
| **Unit** |  | **Campus** | |  | |
| **Email** |  | **Phone** | |  | |
|  |  | | | | |
| **Line Manager** |  | | **Email** | |  |
| **PTC Contact** |  | | **Email** | |  |

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| **SECTION 2: ADJUSTMENT DETAILS** |
| **Workplace impacts of your disability.**  *(Example – unable to take part in online meetings without audio visual support)* |
|  |
| **Workplace adjustment required.**  *(Example – access to audio visual software supports)* |
|  |
| **Emergency arrangements (including personal emergency evacuation plan)**  *Example – an arrangement with the fire warden to access elevators during evacuation and drills* |
|  |
| **Other support** |
|  |
| **Supporting documentation (if required)**  *(e.g. advice from medical practitioner or workplace assessment)* |
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| **SECTION 3: RECORD OF ADJUSTMENTS** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Adjustment** |  | | |
| **Existing/New** |  | **Action Required** |  |
| **Comments** |  | | |
| **Review Date (if required)** |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Adjustment** |  | | |
| **Existing/New** |  | **Action Required** |  |
| **Comments** |  | | |
| **Review Date (if required)** |  | | |

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| --- | --- |
| **Workplace Assessment (if required)** | |
| **Date of last assessment** |  |
| **Date of next review**  **(if required)** |  |
| **Comments:** |  |

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| **Who should be informed of the adjustments?**  *(Example – People, Talent and Culture, Fire Wardens, Team members)* |
|  |

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| **SECTION 4: STAFF MEMBER SIGNATURE** | |
| **Employee** | |
| **Name:** |  |
| **Signature:** |  |
| **Date:** |  |
| **SECTION 5: APPROVAL/CONFIRMATION**  **To be completed by LINE manager.** | |
| **Manager** | |
| **Name:** |  |
| **Signature:** |  |
| **Date:** |  |

Recommended review date (if relevant): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_