**Medical Duty to accommodate Letter**

[INSERT ORGANIZATION LOGO HERE]

[DATE]

[EMPLOYEE NAME & ADDRESS]

**RE: Confirmation of Medical Duty to Accommodate Agreement**

Dear [EMPLOYEE NAME]

This letter is to confirm the Medical Duty to Accommodate Agreement reached between you and the [ORGANIZATION] based on the medical assessment received by your healthcare provider on [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 ACCOMMODATION** | | | |
| [INSERT LIST OF LIMITATIONS] | | | |
| **TERMS OF AGREEMENT** | | | |
| Start Date | | Expected End Date | |
|  | |  | |
| Description of the Modifications | | | |
|  | | | |

This Medical Duty to Accommodate 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 [PHONE NUMBER and EMAIL].

Sincerely,

[INSERT DIGITAL SIGNATURE HERE]

[ORGANIZATION]

[HR MANAGER NAME, TITLE]

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

|  |  |  |  |
| --- | --- | --- | --- |
| Signature  (Employee) |  | Date |  |
| Signature  (Supervisor) |  | Date |  |
| Signature  (HR Department) |  | Date |  |