

**Reasonable Accommodation Request form (Current and New Staff)**

**Section 1:** Workplace needs Assessment

**Purpose of this Form**

This form is intended for staff members at the University of Limerick who wish to request an assessment for reasonable accommodations due to a disability, learning difficulty, or significant ongoing health condition. The assessment will help determine the most effective accommodations tailored to your specific needs.

**Steps for Requesting a Needs Assessment:**

1. **Initial Contact**: If you wish to request a needs assessment, please contact your manager. Your manager will assist you in completing this form.
2. **Submission Process**: Once submitted, your reasonable request form is stored on the secure **HR SharePoint. HR will then confirm receipt of the form.**
3. **Eligibility**: Please refer to required documentation below.

**Required Documentation**  
To access available support, you must provide accepted evidence of your disability, learning difficulty, or significant ongoing health condition. This documentation will be used to assess the impact of your condition and facilitate access to general disability supports.  
 **Review Process**  
The completed form and accompanying documentation will be reviewed by HR and Occupational Health professionals who specialise in understanding the impact of disabilities within the work environment.

**Section 1: Confirmation/ Personal Details**-

I confirm that I have a disability and would like to request a needs assessment. Yes: No:

1. **Name**:
2. **Staff Number**:

1. **Email Address**:
2. **Job Title**:
3. **Department/Division:**
4. **Office/Room Number:**
5. **Line Manager Name:**
6. **Line Manager Email:**
7. **Please Confirm that your Line Manager/ Head of Department is aware of your application**: Yes:  No:

**Note: Your Line manager must be made aware in advance of your application.**

**Section 2: Nature of Disability**

In this section we ask you to provide some further details, including the nature of your disability. This information will only be shared with HR Staff, Line Manager, Head of Department and University of Limericks Occupational Health Physician (or an Occupational Therapist/Specialist appointed by the University).

1. **Please provide the nature of your disability here** (tick multiple boxes as required)

ADD/ADHD  Deaf/Hearing impaired  Mental Health Condition  Dyslexia/Dyscalculia

Autism Spectrum Disorder  DCD/Dyspraxia/ Dysgraphia  Communication disorder

Neurological Condition  Speech and language  Blind/Visual Impairment

Physical Disability/Mobility  Significant ongoing illness  Specific Learning Difficulty

Other  (if other, please expand below)

1. **Please expand on nature of disability if required.**
2. **How does your disability affect (or can potentially affect) your ability to perform the essential functions of your job?**
3. **What supports do you feel you require?**  
   (Details of supports which may have worked in the past or which may be required in the future may be of relevance)

Accessible Building  Assistive Technology- Hardware  Location Restriction

Assistive Technology- Software  Material in Alternative Format

Alternative method of Communications required  Sign Language interpreters 

Specific Work Environment (e.g. lights/ noise/space)  Flexibility in working week

Time off for medical appointments  Flexibility in working hours per day

**Section 3: Confirmation:**

* I acknowledge that all information gathered during the reasonable accommodation request process will be handled and utilised in accordance with the University’s Data Protection Policy.
* I understand that the following individuals may need to be involved in this process: my Line Manager, Head of Department, Health and Safety Officer, HR personnel and selected others when deemed appropriate.
* I further understand that I will be required to provide appropriate documentation relating to my disability from a specialist medical practitioner when attending the University’s Occupational Health Physician to determine any reasonable accommodations which may be required.

**I agree:**  **I disagree:**

**Signed:**  **Print Signature:**   
Please note that where your disability may cause you or another person to be exposed to danger, you are in fact legally required to disclose the disability to an employer. 

**Evidence of a DisAbility Form**

**Instructions for Completion:**

* A GP / Health Professional / Specialist must complete this form.
* This form must be stamped/ accompanied by headed paper.
* Applicants must arrange for this form to be completed on their behalf by one of the following persons: a GP / Health Professional / Specialist

1. **Staff Details**

**Name:**

**Date of Birth:**

1. **GP/Health Professional/Specialist**

**Name, Title of GP/ Health Professional/ Specialist**:

**Address**:

**Phone (Including area code**):

**Position/ Professional Credentials**:

**Date of Report:**

**The GP or other health professional or specialist should now complete sections 3-7 as appropriate:**

1. **Disability Information** (to be completed by the GP/ health professional/specialist)
2. **In my opinion, the staff member presents as being impacted by the following disability type (please tick):**

ADD/ADHD  Deaf/Hearing impaired  Mental Health Condition

Autism Spectrum Disorder  DCD/Dyspraxia/ Dysgraphia

Neurological Condition  Speech and language  Blind/Visual Impairment

Physical Disability/Mobility  Significant ongoing illness

Dyslexia/Dyscalculia  Specific Learning Difficulty  Communication disorder

Other

1. **If not indicated above, please outline the disability/ learning difference /significant ongoing health condition that the staff member presents as being impacted by:**
2. **Date of onset of the above impact:**
3. **Has the staff member been referred to a Consultant or Expert Specialist for a diagnosis**?

Yes:  No:

**If so, please provide the date of referral**:

1. **In your opinion, please briefly describe the anticipated course of the condition, i.e. will remain static, may have periods of relapse/remission, may deteriorate.**

Duration: Ongoing/ Permanent  Temporary  Fluctuating  Relapse/ remit

1. **In your opinion, how does the reported impact of the disability/ learning difference/significant ongoing health condition impact on the staffs’ ability to participate in their role (example, fatigue, concentration, pain, etc.) in Higher Education**?
2. **Please describe any measures currently being taken to treat the reported impact of the disability/ learning difference/significant ongoing health condition (e.g. medication, therapy).**
3. **The GP/Health Professional/Specialist must complete the details below:**

**Signature:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

**Date: IMC Number:**

**Name of GP/ Health Professional/ Specialist**:

**Official Stamp:** This form must be completed, signed and

stamped by the appropriate professional.

If a stamp is not available, this form should be

accompanied by a business card or headed paper.