HUMAN RESOURCES
OCCUPATIONAL HEALTH AND WELLNESS

Employee Request for Accommodation with a Service Animal

Section A: Employee Information: *(to be completed by employee)*

NAME: (Surname)		(Given Names)	Date of Birth (YYYY-MM-DD)
HOME ADDRESS: (Street, City, Postal Code)		HOME/CONTACT PHONE NO.	
DEPARTMENT/COLLEGE	SCHOOL/DEPARTMENT/SERVICE UNIT	JOB TITLE	
FACULTY CHAIR/SUPERVISOR		PHONE NO.	

Section B: Service Animal Information (to be completed by employee)

1. Please provide the species and approximate size of the animal:____
2. Has your service animal received appropriate training to assist with your particular disability? ☐ Yes ☐ No
   If Yes, only service animals trained through Lions Foundation of Canada, Autism Dog Services and National Services are approved at the University. Please provide information regarding the training received (for example, training organization, certificate of training, proof of registration with an accredited organization etc.) to OHW.

Section B: Medical Information (t*o be completed by a qualified medical practitioner).*

Please be advised that by completing this form you are certifying that the information is true and accurate and is in keeping with professional standards outlined by the professional and regulatory bodies that govern your practice. You further understand that all information requested must be **fully** completed to ensure the employer can determine the employee's accommodation.

1. General nature of Illness: ____
2. Is the Employee under your direct, continuous and medically appropriate care for the condition requiring your service animal? ☐ Yes ☐ No
3. Is complete recovery expected? ☐ Yes ☐ No
4. What is the expected duration of this accommodation? ☐ Permanent ☐ Temporary

   If Temporary, please provide an applicable timeline____

   Next Reassessment Date (DD/MM/YYYY): ___________________________________

Name of Patient: ______________________________ **Date of Birth (DD/MM/YYYY)** ______________________

5. What specific activities require the employee's use of the service animal while at work?

____

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6. As part of this accommodation is the service animal expected to be with the employee at all times during the work period?
☐ Yes ☐ No

If No please explain

____

____

7. Do you certify that the employee has a medical condition that results in an impairment and subsequent disability and requires this service animal for reasons related to that disability? ☐ Yes ☐ No

8. Is the patient adequately equipped (emotionally, psychologically, physically and socially) to manage the behaviour and needs of the animal, as well as any reasonably foreseeable responses from the public to the animal's behaviour/presence?
☐ Yes ☐ No

9. If there are other accommodation needs other than the use of a service animal, please complete the enclosed Functional Capacity Form (FCF).

By affixing my signature below, I certify that I am a qualified healthcare provider and that I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.

TREATMENT PROVIDER NAME: (Please Print)______________________ TELEPHONE: ______________

ADDRESS:______________________________________ FAX: ______________

SIGNATURE:______________________________________ **DATE:** ______________

Once competed please return by confidential fax to 519-780-1796 or upload the form to the OHW Secure Drive.

Any costs associated with providing the above information will be the responsibility of the employee.