

Workplace Adjustment Request

WHS-PRO-FORM-006f



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Overview

This form is to be completed following review of the WHS-PRO-006 Health Management Workplace Adjustments Procedure.

JCU Staff are to submit a Workplace Adjustment Request when requiring modifications to their work environment or tasks to enable safe completion of their inherent role requirements. Workplace adjustments are available to staff experiencing an "injury and/or health condition" as per the definition in the WHS-POL-006 Health Management Policy and WHS-PRO-006 Health Management Workplace Adjustments Procedure.

Not all workplace adjustments require completion of this form e.g.

- If you are requesting to work remotely, please refer to the [Remote Working Procedure](#).
- Workplace Flexibility Requests and requests to Vary Your Work Hours must be submitted on ServiceNow to Human Resources. Temporary workplace adjustments that align with a workplace rehabilitation program will be recorded on the Suitable Duties Plan.

Process

Step 1: Staff Member to complete and submit Part A to their Supervisor.

Step 2: Supervisor to consider the request in line with the accompanying procedure and will consult with the Injury Prevention & Management Advisor (IPaMA) and Head of Work Unit as necessary. The Supervisor will discuss the outcome of the request and will provide a written record of the request outcome using Part B or C of this form.

The Staff Member, Supervisor, Head of work unit, and IPaMA may retain a copy of the form.

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Part A- Workplace Adjustment Request (Staff member to complete)

Personal details	
Staff member:	Position:
Directorate/College:	Location:
Supervisor:	Date:

Workplace Adjustment Request
What adjustment/s are you requesting? <i>If you require advice on what may be reasonable to request, you may speak with a JCU Injury Prevention and Management Advisor (IPaMA).</i>
Why do you require these adjustment/s? <i>Please describe how these adjustments can help you perform the inherent requirements of your role.</i>
How long do you anticipate needing this adjustment/s? <i>Adjustments may be temporary or permanent. If you are unsure, please provide an estimated timeframe.</i>
Supporting documentation <i>Supporting information may include letter from a treating medical practitioner / health care professional or any other relevant information that might help to inform a decision.</i>
<input type="checkbox"/> I have attached supporting documentation relevant to my request <input type="checkbox"/> I have not provided supporting documentation

Signature	
Staff Member I confirm that all information included in this submission is correct and reflective of my needs and/or advice provided to me by a health care professional.	
Name:	Signature:
Date signed:	

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Part B Workplace Adjustment Approval (Supervisor/IPaMA to complete)

Supervisors that require assistance prior to approving the request are to contact the IPaMA and provide a copy of the Workplace Adjustment Request Part A. The Supervisor must discuss the request and any outcome with the Staff member prior to providing the formal outcome.

Workplace adjustment request supported
<input type="checkbox"/> I have reviewed the WHS-PRO-006 Health Management Workplace Adjustments Procedure, section 4. <input type="checkbox"/> I have discussed the request and outcome with the Staff member prior to providing the formal outcome. <input type="checkbox"/> I am satisfied with the supporting documentation provided (if required) <input type="checkbox"/> I believe the request is reasonable and support this workplace adjustment.
Notes:
Supporting documentation
<input type="checkbox"/> Supporting documentation is on file Title: Date issued:
Implementation, Duration & Review
Expected date of implementation: Duration: Reasonable adjustment to cease/be reviewed on date: Note: The Staff member and/or Supervisor is to request a review at any time if the workplace adjustment is no longer suitable, required, or effective.

Signatures	
Staff Member	
Name:	Signature:
Date signed:	
Supervisor	
Name:	Signature:
Date signed:	
Injury Prevention and Management Advisor (IPaMA)	
Name:	Signature:
Date signed:	

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Part C Workplace Adjustment Alternative

(Supervisor/Head of work unit to complete in consultation with IPaMA)

Complete this form if you, as the Supervisor or Head of work unit, are unable to accommodate the requested workplace adjustment and have consulted with the IPaMA to explore and, where possible, provide alternative adjustments.

The Supervisor must discuss the request and any outcome with the Staff member prior to providing the formal outcome.

Workplace adjustment/s request not supported

- ☐ No, I do not support the requested workplace adjustment.
- ☐ I have reviewed WHS-PRO-006 Health Management Workplace Adjustments Procedure
- ☐ I confirm that I have sought advice from the IPaMA
- ☐ I have discussed the request and outcome with the Staff member prior to providing the formal outcome.

Explanation as to why the workplace adjustment request was deemed unreasonable:

Proposed alternative workplace adjustment/s if applicable

Rational for proposed alternative workplace adjustment/s if applicable

Supporting documentation

- ☐ Supporting documentation is on file

Title:

Date issued:

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Outcome
<input type="checkbox"/> I confirm that I am working with the Staff member and WHS / IPaMA to implement the proposed alternative adjustment/s. <input type="checkbox"/> JCU is unable to accommodate the workplace adjustment request and no alternative adjustments can be provided. <input type="checkbox"/> JCU is unable to accommodate the workplace adjustment request and the alternative adjustments have been declined by the Staff member.
Implementation, Duration & Review
<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary. Expected date of implementation: Duration: Reasonable adjustment to cease/be reviewed on date: Note: The Staff member and/or Supervisor is to request a review at any time if the workplace adjustment is no longer suitable, required, or effective.

Signatures	
Supervisor I am unable to support the initial workplace adjustment request and have explored alternative options for meeting the needs of my Staff member, with the outcome as indicated above.	
Name:	Signature:
Date signed:	
Head of work unit I confirm that I am unable to support the initial workplace adjustment request and have explored alternative options for meeting the needs of my Staff member, with the outcome as indicated above.	
Name:	Signature:
Date signed:	
Injury Prevention and Management Advisor (IPaMA) I have been consulted and agree with the proposed alternative options	
Name:	Signature:
Date signed:	
Staff Member I have been consulted and accept the outcome as indicated above.	
Name:	Signature:
Date signed:	