

CORPORATE POLICY

POLICY NO. 01-19-01	DEPARTMENT Administration
SUBJECT Integrated Accessibility Standard Regulation Policy	EFFECTIVE DATE January 15, 2018
APPROVED BY Resolution No. 11-2018	PAGES 1 - 15
REPLACING/AMENDING NEW	DATE January 15, 2018

PURPOSE

Under the Accessibility for Ontarians with Disabilities Act, 2005, all public and private sector organizations must meet the requirements of accessibility standards established by regulation. This policy establishes the Integrated Accessibility Standards Regulation in the areas of Employment, Information and Communication and Transportation for the Municipality of Oliver Paipoonge in accordance with Ontario Regulation 191/11. This regulation came into force July 1, 2011.

The Municipality of Oliver Paipoonge is committed to meeting the accessibility needs of persons with disabilities in an effective and timely manner by preventing and removing barriers for persons with disabilities in accordance with the *IASR*. The Municipality's goal is to foster an inclusive organizational culture that is guided by the principles and requirements of the *AODA*, the *IASR* and the *Code*.

POLICY

This policy has been drafted in accordance with the Regulation and addresses how the Municipality achieves accessibility through meeting the Regulation's requirements. It provides the overall strategic direction that we will follow to provide accessibility supports for Ontarians with disabilities.

1. Multi Year Accessibility Plan
The Municipality of Oliver Paipoonge has developed and will maintain a Multi-Year Accessibility Plan (the "MYAP") that sets out the Municipality's strategy for preventing and removing accessibility barriers from our workplaces and meet its requirements of the *IASR*. The MYAP will be reviewed and updated at least once every five years.
2. Self Service Kiosks
If the Municipality of Oliver Paipoonge procures or acquires self-service kiosks in the future, we will have regard to the accessibility for persons with disabilities and ensure that the kiosks incorporated appropriate accessibility features.
3. Training
Training has been provided to all Municipal employees and volunteers who deal with members of the public or other third (3rd) parties on behalf of the Municipality, and those involved in the developing Integrated Accessibility Standards policies, practices and

procedures received training on Integrated Accessibility Standards and Human Rights Code as it pertains to persons with disabilities.

Training has been provided as soon as practicable upon an individual being assigned the applicable duties, through online resources;

- AccessForward – Training for an Accessible Ontario, www.accessforward.ca
- Ontario Human Rights Commission <http://www.ohrc.on.ca/>
- Serve-Ability: Transforming Ontario’s Customer Service

Keeping an updated record of the training, including the date to which training is provided and the number of individuals to whom it is provided. The names of individuals trained will be recorded for training administration purposes, subject to the *Municipal Freedom of Information and Privacy Act* (MFIPPA).

4. Procuring and Acquiring of Goods, Services or Facilities

The Municipality shall incorporate accessibility criteria and features into procuring or acquiring goods, services or facilities.

5. Information and Communications

Upon request, The Municipality of Oliver Paipoonge will provide or arrange for the provision of accessible formats and communication supports for persons with disabilities in a timely manner that takes into account each person’s accessibility needs due to disability and (if applicable) at a cost that is no more than the regular cost charged to other persons.

The Municipality will consult with the person making the request for an accessible format or communication supports when determining the suitability of an accessible format or communication supports.

The Municipality will continue to advise the public about the availability of accessible formats and communication supports with respect to its feedback processes on the Municipalities website.

The Municipality will ensure that its website(s), including web content on such site, conforms to the World Web Consortium Web Content Accessibility Guidelines (WCAG) 2.0 at Level AA, except where meeting the requirement(s) is not practicable.

6. Employment

Recruitment, Assessment and Selection: In our recruitment processes, the Municipality will advise employees and public about the availability of accommodation for applicants with disabilities.

The Municipality will notify job applicants, when they are individually selected to participate further in an assessment or selection process that accommodations are available upon request in relation to the materials or processes to be used.

If a selected job applicant requests accommodation relating to their participation in the hiring process, the Municipality will consult with the individual and provide or arrange for the provision of suitable accommodation that takes into account the applicant's disability-related needs.

When making offers of employment, the Municipality will notify successful applicants of;

- a) our policies for accommodating employees with disabilities
- b) the availability of information in an accessible format and/or communication supports in consultation with the employee with a disability

Individualized Emergency Response Information and Plan (Appendix A): The Municipality will provide individualized workplace emergency response information to employees with disabilities where the disability is such that individualized information is necessary and as soon as practicable after learning of the need for accommodation due to an employee's disability.

Where an employee who receives individualized workplace emergency response information requires assistance, a designated personal assistant will be provided and, with the employee's consent the Municipality will review individualized workplace emergency response information, at minimum, whenever:

- the employee moves to a different location within the corporation;
- the employee's overall accommodation needs or plans are reviewed; or
- the Municipality reviews its general emergency response policies.

Individualized Accommodation Plan (Appendix B): The Municipality will develop and maintain a written process for the development of documented individual accommodation plans for employees with disabilities.

Return to Work Plan (Appendix C): The return to work process will outline the steps that the Municipality will take to facilitate a return to work and will include documented individual accommodation plans. An independent Medical Assessment may be requested to assist and determine a suitable accommodation plan at no cost to the employee. Policy No. 02-04-01 Return to Work Policy was approved by Council on March 27, 2017.

The Municipality will develop and maintain a documented return to work process for its employees who have been absent from work due to a disability and who require disability-related accommodations in order to return to work.

Functional Abilities Assessment Form (Appendix D): To be completed by the physician.

Performance Management, Career Development and Advancement: The Municipality will take into account the accessibility needs of employees with disabilities, as well as individual accommodation plans, when conducting performance management, or providing career development and advancement to employees.

THE CORPORATION OF THE MUNICIPALITY OF OLIVER PAIPOONGE**Individual Emergency Response Work Sheet-Appendix A**

***Available in alternate format upon request**

Section 1: Employee Emergency Information Worksheet

Please complete this worksheet to help us identify the barriers that could arise in an emergency situation and provide suggestions on how to overcome them. Your input will help us provide you with individualized emergency information.

The information collected is confidential and will only be shared with your consent. You **do not** have to provide details of your medical condition or disability, only the type of help you may need in an emergency situation.

Date: _____

Employee Information

Name:

Extension:

Email:

Manager:

Emergency Contact Information

Name:

Telephone:

Mobile Phone:

Email:

Relationship:

Date: January 15, 2018

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Work Location

Do you work in different locations on a regular basis? (Please circle) Yes No

If yes, list locations

Potential Emergency Response Barriers

1. Can you see or hear the fire/security alarm signal from your work station?

(Please circle) Yes No Don't Know

If no, what would help you know that the alarm was flashing/ringing?

2. Can you activate the fire/security alarm system?

(Please circle) Yes No Don't Know

3. Can you talk to emergency staff?

(Please circle) Yes No Don't Know

If no, what help would you need to exit the building?

4. Can you use the emergency exits?

(Please circle) Yes No Don't Know

If no, what help would you need to exit the building?

5. Could you find the exit if it was smoky or dark?

(Please circle) Yes No Don't Know

If no, what would help you find the exit?

6. Can you exit the building by yourself?

(Please circle) Yes No Don't Know

If no, what would help you get out?

7. Would you be able to evacuate the building during a stressful and/or crowded situation?

(Please circle) Yes No Don't Know

If no, what would help you evacuate?

8. Can you read/access our emergency information?

(Please circle) Yes No Don't Know

If no, what would make this information available to you?

9. If you need help to evacuate, what instructions do people need to help you?

Instructions: (Use additional sheets as necessary)

10. If you need other accommodations in an emergency situation please list them here.

Accommodations: (Use additional sheets as necessary)

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Individual Accommodation Plan – Appendix B

***Available in alternate format upon request**

Confidential when completed				
Employee Information				
Last Name		First Name		
Title/Department				
Manager Information				
Last Name		First Name		
Accommodations		Next Plan Review		
Start Date	End Date	Enter Date	or	Frequency
Limitations				
List any functional limitations that the employee experiences, how it affects different aspects of his/her job and if each tasks is an essential part of the role				
Limitation(s)				
Task/activities affected				
Essential job requirements? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Accommodations				
Using a list of tasks from the limitations section above, identify what types of accommodation or support would help the employee accomplish the task. List a strategy or tool that will provide the accommodation.				
Task(s)				

What must the accommodation achieve?	
Accommodation strategy	
Implementation	
List the actions required to achieve the accommodation(s) identified in the prior section	
Action	
Assigned to	
Due Date	
Information sources	
Identify and include the contact information for any experts consulted when building the plan (e.g., human resources, family doctors, specialists)	
Last Name	First Name
Title/Role	
Email Address	Telephone Number
Related Documents	
<input type="checkbox"/> Employee emergency plan (if applicable)	
<input type="checkbox"/> Accessible format of the individual accommodation plan	
<input type="checkbox"/> Type(s) of accessible formats and/or communication support the employee needs (if applicable)	
<input type="checkbox"/> Return to Work Plan (if applicable)	
<input type="checkbox"/> Other (specify)	
Comments/Notes	
Use this section for any additional comments	
Signatures	
Employee's Signature	Date

Manager's Signature	Date
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Return to Work Plan – Appendix C

*Available in alternate format upon request

Confidential when completed		
Employee Information		
Last Name:	First Name:	
Manager Information		
Last Name:	First Name:	
Pre-injury Job Information		
Pre-injury Job Title:		
<ul style="list-style-type: none"> • Job description attached <input type="checkbox"/> Yes <input type="checkbox"/> No • Job tasks and demands attached <input type="checkbox"/> Yes <input type="checkbox"/> No 		
Return to Work Goal		
Plan Start Date:	Plan End Date:	
Return to Work Plan Goal (select one):		
<input type="checkbox"/> Pre-injury job <input type="checkbox"/> Pre-injury job, with accommodations, in accordance to FAF – Appendix A. <input type="checkbox"/> Alternate work. If alternate work, provide job title or description or work.		
Health Recovery		
Accepted area(s) of injury:		
Is there an active treatment plan that impacts return to work?		
<input type="checkbox"/> No <input type="checkbox"/> Yes, provide details		
Treating Health Professional(s):	Phone No.:	
Functional Abilities		
<ul style="list-style-type: none"> • Has functional abilities information been received? <input type="checkbox"/> Yes <input type="checkbox"/> No • Attached to Return to Work Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, when will functional abilities information be received? Date: _____		
Pre-injury Job Duties		
	Yes	No
Are the physical demands of the job within the worker's functional abilities?		
Are the essential duties of the job within the worker's functional abilities?		

List job duties the worker can perform;		
Accommodations and transitional measures		
	Yes	No
Are accommodations/reasonable adjustments to the job duties required?		
Are accommodations/reasonable adjustments to the workplace/workstation required?		
Is training required?		
If the measures will be phased in or out, include and start/end date. Attach additional pages, if needed.		
<input type="checkbox"/> Adjusted work hours/days	Start Date	End Date
<input type="checkbox"/> Adjusted work location	Start Date	End Date
<input type="checkbox"/> Adjusted job requirements	Start Date	End Date
<input type="checkbox"/> Assistive device(s)	Start Date	End Date
<input type="checkbox"/> Additional support	Start Date	End Date
<input type="checkbox"/> Other	Start Date	End Date
Assignment to alternate position		
Complete this section if the employee will not be returning to his/her original job. The assignment to an alternate position may be temporary or permanent.		
Job title	Length of assignment	
Description new position		
List any training requirement and safety precautions		
Work Schedule		
Work Period (from/to)	Days schedule each week and number of hours per day	Additional Comments on Work Schedule
	Sun Mon Tues Wed Thurs Fri Sat	
How will the worker be paid for the duration of the Return to Work Plan?		
Rate of pay (e.g., hourly):		

<p>Worker will be paid for hours worked only, Or, <input type="checkbox"/></p> <p>Employer will pay full regular wages <input type="checkbox"/></p>	
Comments/Notes	
<p>Use this section for any additional comments</p>	
<p>If there are any concerns during the course of the Return to Work Plan, please discuss immediately and contact WSIB Case Manager (if applicable) if you are unable to resolve.</p> <p>Consider providing a copy of the approved Return to Work Plan to the WSIB Case Manager (if applicable) if this is a work-related injury/illness.</p>	
Signatures	
Employee Name:	
Employee's Signature	Date
Supervisor Name:	
Supervisor's Signature	Date

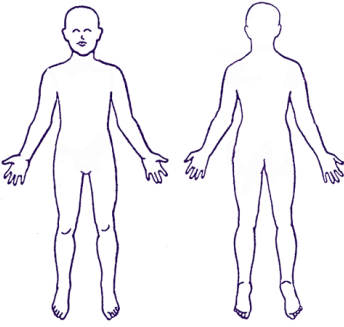
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Functional Abilities Assessment Form – Appendix D

***Available in alternate format upon request**

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Functional Abilities Form

A Employee Information <i>(To be completed by the employee's supervisor)</i>					
Employee's Surname	First Name	Injury/illness is: <input type="checkbox"/> Work-Related <input type="checkbox"/> Non-Work Related	Date of Injury/Illness	Today's Date	
Employee's Job Title	Employee's regular work hours:	Supervisor's Name: Tel No. () -			
B Assessment <i>(Part B, C and D to be completed by attending physician)</i>					
Due to injury or illness this employee has: <input type="checkbox"/> Normal functional Abilities (fit for Regular Duties) (No additional needed. Please sign section E) <input type="checkbox"/> Reduced Functional Abilities (Please complete Section C, D & sign section E)					
C Functional Abilities: <i>(if unable to test, please estimate)</i>					
Step 1 Please circle the appropriate letter(s) & Body area(s) to indicate the affected area(s)	Step 2 Please indicate Reduced abilities	Step 3 Please indicate extent of abilities		Comments	
 <p>A Systemic or Non-Physical B Head (incl. Vision, hearing, speech) C Neck D Upper back, chest, upper abdomen E lower abdomen F Lower abdomen G Shoulder or upper arm I Wrist or hand J Hip or upper leg K Knee or lower leg L Ankle or foot M Respiratory/Aerobic</p>	Walk	Maximum Duration (<i>hours</i>): 1 2 4 5+ Other <input type="checkbox"/> Short distance only <input type="checkbox"/> No walking			
	Stand	Maximum Duration (<i>hours</i>): 1 2 4 5+ Other			
	Sit	Maximum Duration (<i>hours</i>): 1 2 4 5+ Other			
	Lift/Carry	Occasionally	Weight (kg)	<9kg – Specify	
	Floor – waist		21 16 9		
	Waist – shoulder		21 16 9		
	Above shoulder		21 16 9		
	Bend/Twist	Occasionally	Not at all	Specify	
	Neck Back				
	Push/pull	Occasionally	Not at all	Specify	
Moderate load Light load					
Climb	Occasionally	Not at all	Specify		
Flight of stairs Few steps					
Reach	Occasionally	Not at all	Specify		
Above shoulder Below shoulder					
Use Hands for: Writing	Occasionally	Not at all	Specify		
	L R	L R			

	Typing	L R	L R		
	Fine manipulation	L R	L R		
	Grasping	L R	L R		

	Sensory Specify:	To See	To Hear	To Speak	To Maintain Balance
	Concentration	<input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor			
	Judgement	<input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor			
	Operate Equipment	Specify:			
	Hours of work	Specify: Normal hours or graduated RTW?			
	Prescription medication	Will it affect ability to work/drive:			
	Can this person work independently?	With Supervision?	With Assistance?		

Other Comments/Instructions (NO DIAGNOSIS OR TREATMENT):

D Normal functional abilities may resume in: 1-3 days 4-7 days 8-14 days Specify:

*Other: Employee is not medically fit for regular duties, will require periodic reassessments for effective rehabilitation. Scheduled reassessment date for:

This authorizes my attending physician to provide the information requested above to The Corporation of the Municipality of Oliver Paipoonge. Employee's Signature: Date:

E Physician's name & Address:	Physician's Signature:
	Physician's Telephone No:
	Date: