**Disability/Neurodiversity Employee Needs Assessment**

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| --- | --- |
| Date |  |
| Employee name |  |
| Line Manager name |  |
| Person conducting the Needs Assessment |  |

|  |  |
| --- | --- |
| Details of the disability/neurodiversity |  |

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| Areas identified that need support | Adjustment to put in place | Person responsible for implementing the adjustment | Review date (6 months) |
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| Signed by employee |  |
| Signed by person conducting the needs assessment |  |