College of
HEALTH AND CARE
PROFESSIONALS OF BC

Examination and Assessment Accommodation Request Form

A candidate who requires examination or assessment accommodations may request them by completing this form and providing any supporting documentation to CHCPBC. Examples of situations where a request for an accommodation is considered include, but are not limited to, a permanent disability, temporary disability, medical condition or disorder, faith-based or cultural requirement. Candidates with faith-based or cultural requests are only required to complete Section A.

Consent to Disclose Information

By submitting this form, you are providing your consent to disclose your personal information to CHCPBC. For more information on how we protect your personal information and privacy, please see our **Privacy Notice.** If you have questions, comments, concerns, or requests, please contact exams@chcpbc.org.

Instructions:

1. Candidate fills out Section A: Candidate Documentation
2. Candidate contacts their healthcare provider (see page 5 for more information) to fill out Section B OR their academic accessibility advisor, if applicable, to complete Section C
3. Healthcare provider or academic accessibility advisor emails completed form to exams@chcpbc.org

Section A: Candidate documentation

Candidate name: _____

CHCPBC licensee/applicant number: _____

First examination/assessment:

Select an item

Second examination/assessment (if applicable):

Select an item

Describe the accommodation(s) you are requesting. Be as specific as possible.

Describe how you are prevented from completing the examination(s)/assessment(s) in the usual method and/or environment. (Disclosure of a diagnosis is not required).

What past testing accommodations have you been granted, if any? If accommodations were granted during your education program, please provide documentation of this. Please note that receiving accommodations during your education program does not guarantee that you will be granted accommodations on this examination or assessment.

DECLARATION:

I certify that the above information is complete and accurate to the best of my knowledge, and I understand that any misrepresentation contained in this request may result in a delay of and/or the revocation of my eligibility to write the examination/ assessment.

Candidate signature: Date:

Section B: Healthcare professional documentation

We rely on the healthcare professional's expertise to recommend a specific accommodation based on their understanding of the candidate's functional limitations and needs. This section should be completed by a qualified healthcare professional who is familiar with the candidate's functional limitations and accommodation needs. Please see the list of recommended healthcare professionals on the next page.

Full name of healthcare professional: _____

Licence number: _____

Telephone: _____ Email: _____

Professional designation/title: _____

Date of candidate's last visit: _____

I have known this candidate since _____.

I confirm that I have used my own professional judgment and identified a clear link between the candidate's needs and how they are addressed in the accommodation. I understand that the purpose of an accommodation is to provide equity, not advantage.

I verify that the candidate has a functional limitation that requires accommodation:

☐ Yes

☐ No

Please provide a brief history and description of the functional limitations that prevent the candidate from taking the examination/assessment in the usual method and/or environment: *(Attach a separate letter if needed)*

Please describe the accommodations you recommend the candidate receive to mitigate their functional limitations within the specific context of their examination(s)/assessment(s):

Signature: Date:

Medical documentation

	Recommended healthcare professional to complete Section B
Hearing impairment	Audiologist or other qualified healthcare professional
Vision impairment	Optometrist, ophthalmologist, or other qualified healthcare professional
Learning disability	Psychologist, psychiatrist, or other qualified healthcare professional
Physical disability or condition	Physical therapist, occupational therapist, or other qualified healthcare professional
Attention Deficit Hyperactivity Disorder	Psychologist, psychiatrist, registered social worker, or other qualified healthcare professional
Psychiatric disorder	A qualified healthcare professional (must be competent to evaluate and diagnose psychiatric disabilities) (Evaluation must have been completed within the last 12 months)
Autism Spectrum Disorder	An appropriate healthcare professional
Brain injury	An appropriate healthcare professional
Dietary requirements	An appropriate healthcare professional

Section C: Academic accessibility advisor/services

Name: _____

Telephone: _____ Email: _____

Professional designation/title: _____

Date of last contact with candidate: _____

I confirm that I have used my own professional judgement and identified a clear link between the candidate's needs and how they are addressed in the accommodation.

I verify that the candidate has a functional limitation that requires accommodation:

☐ Yes

☐ No

Please provide any relevant academic accommodation documentation.

Please provide a description of the functional limitations that prevent the candidate from taking the examination/assessment in the usual method and/or environment:
(Note that disclosure of a specific diagnosis is not required)

What accommodations did the university make available to the candidate during their education program(s)?

Please describe the accommodations you recommend the candidate receive to mitigate their functional limitations within the specific context of their examination(s)/ assessment(s):

Signature: Date: