



FOR OFFICE USE ONLY

Application No.:

Date Received:

TESTING ACCOMMODATION APPLICATION FORM

The information requested and any documentation regarding your disability and need for accommodation in taking the registration examinations will be treated confidentially and will not be shared with any outside source, other than the testing agency, without your expressed written permission. Requested accommodations are subject to the approval of the CTCMPAO.

1. CONTACT INFORMATION (confirmation will be sent by email)

Street No. & Name (Required)

Suite No.

City (Required)

Province (Required)

Country (Required)

Postal Code (Required)

Telephone (Required)

Alternate Phone

Fax

Email Address (Required)

2. EXAMINATION

For which of the following examination(s) are you requesting accommodation?

- Jurisprudence Course Test
- Safety Program Test

Examination Date(s): _____
(mm/dd/yyyy)

3. ACCOMODATION(S) FOR THE SECIAL NEEDS REQUESTED DUE TO DISABILITY

Please check all that apply:

- Additional Time (specify additional number of minutes needed: _____)
- Other:

You are required to attach supporting documents for your special need accommodation request and submit the "Documentation of Disability-Related Needs Form".

4. SIGNATURE

Please note that the CTCMPAO might require further information from your past and/or present treating regulated health professional and will contact him/her directly if necessary. In submitting this form, you are providing your authorization to your past and/or present treating regulated health professional to disclose further information to the CTCMPAO.

Name of Applicant (Please print)

Signature of Applicant

Date of Signature
(mm/dd/yyyy)

ACCOMMODATION FOR SPECIAL NEEDS DOCUMENTATION OF DISABILITY-RELATED NEEDS

If you have a disability that requires an accommodation in taking the registration examination, please have this section completed by an appropriate professional (i.e., physician, psychologist, rehabilitation counsellor or other professional registered with a professional regulatory body in Ontario) to certify that your disabling condition requires the requested test accommodation.

I have known _____ since _____
(Candidate Name) *(Date)*

in my capacity as a _____
(Professional Title)

Because of the nature of the candidate's disability

(Description of the candidate's disability)

it is my opinion that the candidate should be accommodated by providing the following *(check all that apply)*:

Additional Time (specify additional number of minutes needed: _____)

Other: _____

Name _____
(Print)

Signature _____

Title _____

Date _____

Professional Regulatory _____ Registration No. _____