Verification of Candidate's Condition Form

To be Completed by the Candidate

Candidate Name	
Do you authorize the registered professional named below to share information concerning the functional impact of your condition (disability, illness, injury, medical condition, pregnancy-related need, or maternity-related need) with CARB-TCMPA for the purpose of addressing your accommodation request?	☐ Yes ☐ No

Candidate's Signature _____ Date _____

To be Completed by a Registered Professional Responsible for the Candidate's Care/Treatment

Information for Registered Professionals

The Candidate has requested accommodation for a Canadian Alliance of Regulatory Bodies of Traditional Chinese Medicine Practitioners and Acupuncturists (CARB-TCMPA) licensing examination based on disability, illness, injury, medical condition, or pregnancy- or maternity-related need. To address the Candidate's request, CARB-TCMPA requires supporting documentation from a registered professional responsible for the Candidate's care/treatment and, if applicable, licensed to diagnose the condition for which accommodation is being requested.

Your input will be essential in determining appropriate examination accommodations for the Candidate. You must have made, or be able to confirm, the diagnosis of the disability for which the Candidate is requesting accommodation. The goal of the accommodation is to create an equitable examination by ensuring that licensing candidates are not effectively barred from qualifying for practice because of one or more Human Rights Code grounds. *Please ensure the Candidate has signed above and consented to share their information.*

Full Name	
Profession	
Name of Regulatory Body	
Licence / Registration No.	
Office / Organization	
Mailing Address	
Daytime Phone	

Description of the Pan-Canadian Examinations

The examinations test competencies required for entry-level practice, with a focus on those competencies that have the most direct impact on the protection of the public and on safe, effective, and ethical practice. The questions assess the following levels of cognitive ability: remembering, comprehension and application, and analysis and interpretation.

The examinations are self-study and closed book. Each examination includes a multiple-choice component and clinical case component. Each component is either 2.5 hours (Acupuncturists/TCM Herbalists exams) or 3.5 hours (TCM Practitioners exam) held on consecutive days. The examinations contain a mixture of case-based and independent multiple-choice and multiple-select questions. The examinations are delivered through a secure, browser-based platform at computer-based testing centres across Canada.

Candidates may 'bookmark' or 'flag' questions to which they wish to return. The examination is best viewed using one of the three available font sizes. Candidates may zoom in and out using their mouse, which will result in a scroll bar being used to navigate within the question.

Candidate Name	
How long has the candidate been in your care?	
Do you confirm that the candidate has a condition* that affects their ability to write the examination(s) under standard testing conditions as outlined above? (disability, illness, injury, medical condition, pregnancy- or maternity-related need)***	☐ Yes ☐ No
When was the candidate diagnosed with this condition?	
Did you diagnose this condition?	☐ Yes ☐ No
If you did not diagnose this condition, did you confirm this condition? (leave blank if answer above is "yes")	☐ Yes ☐ No

Functional Limitations	*In this section, please describe the functional limitations associated with the Candidate's condition (disability, illness, injury, medical condition, pregnancy- or maternity-related need) and explain how they impact the Candidate's ability to complete the examination under standard testing conditions as outlined above.*

Recommended Accommodation(s)	*In this section, please describe the recommended accommodation(s) for the Candidate. Be as specific as possible. For example, if you are recommending examination materials in an alternative format, specify the type of alternative format requested. If you are recommending any adaptive technology/software or other physical resources, specify the resources requested. If you are recommending additional writing time to complete the exam, indicate the amount of additional time recommended.*

I confirm that the information I have provided is accurate to the best of my knowledge and expertise and is within my scope of practice.

_____

Registered Professional's Signature

_____

Date

Professional Stamp