



Examination Testing Accommodations Candidate Application Form

This form must accompany your Application for Exam Eligibility

The information requested below and any documentation regarding your disability and need for accommodation to take the registration examination will be treated confidentially. Information may, in some circumstances, be relevant to eligibility for registration, particularly around the fitness to practice requirements. No information will be shared with any outside source without your expressed written permission.

Candidate Information

Name

Address

Exam

Language of Exam

Name/Type of Disability

Describe why this disability prevents you from writing the exam in the usual method and/or environment:

Accommodation(s) Requested for Examination

(check all that apply)

- Separate Room
- Recorder (who fills in answers)
- Additional Time (please note you are already given six hours to complete the the NCLEX-RN exam):
 - 2 more hours
 - 3 more hours
 - 6 more hours
 - Other (hours): _____
- Other (please specify) _____

Reader

Adjustable Font Size

Adjustable Contrast

Screen Magnifier

Describe the testing accommodations that you have received in the past through your nursing education program:

Candidate Declaration

I acknowledge and agree that any and all information submitted to the College for the purpose of making or supporting a request for testing accommodations may be used by the College for other regulatory purposes, consistent with its governing legislation, the Registered Nurses Act and the Registered Nurses Regulation.

Candidate Signature

Date



Documentation of Disability Related Needs Form

The candidate must complete Section A of this form and forward the form to a qualified health professional who, in Section B, must describe the accommodations being requested, along with rationale for this recommendation. Submitting this form to the health professional provides them with consent to release information regarding your condition. **The health professional must send the completed form directly to the College by mail, fax or email.**

Section A - Candidate Information

Name _____

Date _____

Signature _____

Section B - Health Professional to Complete

I have known	(name of candidate)	since	(date)
in my capacity as a	(professional title)	Due to the nature of the candidate's disability	(description of disability)

it is in my opinion that the candidate requires the following accommodations: (check all that apply)

- Separate Room
- Recorder (who fills in answers)
- Additional Time (please note candidates are already given six hours to complete the the NCLEX-RN exam):
 - 2 more hours
 - 3 more hours
 - 6 more hours
 - Other (hours): _____
- Other (please specify) _____
- Reader
- Adjustable Contrast
- Adjustable Font Size
- Screen Magnifier

Please provide the following information to support this recommendation. Please attach additional pages, supporting letters and/or reports as necessary. For testing accommodation requests based on a learning disability, a copy of the most recent Psycho-educational Assessment must be included with this form.

Approximate date the disability was first diagnosed and/or identified: _____

A brief history and description of the disability including the functional limitations which prevent the candidate from writing the exam in the usual method and/or environment.

A description of the current treatment plan and why this is not effective in overcoming the functional limitations of the disability, thereby necessitating the above accomodations.

Name	Title	Telephone
Email	Signature	Date



Documentation of Previous Testing Accommodations

The candidate must complete Section A of this form and forward the form to the Disability Services or Accessibility Services Department at your educational institution to complete Section B. Submitting this form to the Disability Services or Accessibility Services Department provides them with consent to release information regarding your disability. **The educational institution must send the completed form directly to the College by mail, fax or email.**

Section A - Candidate Information

Name

Date

Signature

Section B - Educational Institution to Complete

I have known (name of candidate) since (date)

in my capacity as a (professional title)

Please provide the following information. Please attach additional pages, supporting letters and/or reports as necessary.

A description of the candidate's disability:

Approximate date the candidate first started receiving accommodations in the nursing program:

A description of the accommodations granted to the candidate during the course of the nursing program:

Any other comments:

Name Title Telephone

Email Signature Date