College of Registered Nurses of Manitoba

890 Pembina Highway
Winnipeg, MB R3M 2M8

P 204-774-3477
TF (Manitoba) 800-665-2027
F 204-775-7117

registration@crnm.mb.ca

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 ☐ Reader ☐ Adjustable Font Size
☐ Recorder (who fills in answers) ☐ Adjustable Contrast ☐ Screen Magnifier

☐ 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) _____

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 _____

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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 ☐ Reader ☐ Adjustable Font Size
☐ Recorder (who fills in answers) ☐ Adjustable Contrast ☐ Screen Magnifier

☐ 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) _____

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

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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