

TESTING ACCOMMODATIONS CANDIDATE APPLICATION FORM

The information requested below and any documentation regarding your disability and need for accommodation in taking the certification examination will be treated confidentially and will not be shared with any outside source other than the National Dental Hygiene Certification Board (NDHCB) without your expressed written permission.

NAME: _____

ADDRESS: _____

City	Province/Territory/state	Postal/Zip Code
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DATE OF EXAMINATION: _____

NATURE OF DISABILITY: _____

**ACCOMMODATION(S) REQUESTED FOR EXAMINATION
(check all that apply)**

- | | |
|---|---|
| <input type="checkbox"/> LARGER TEXT TEST | <input type="checkbox"/> AUDIO RECORDING OF TEST |
| <input type="checkbox"/> SEPARATE ROOM | <input type="checkbox"/> ADDITIONAL TIME (SPECIFY TIME NEEDED): _____ |
| <input type="checkbox"/> OTHER (PLEASE SPECIFY) _____ | |

COMMENTS: _____

SIGNATURE: _____ DATE: _____

NOTE

Requests for Accommodations must be submitted to the NDHCB 60 days prior to the examination date (as you apply for the examination).

Requested accommodation(s) are subject to the approval of the NDHCB.

NDHCB will confirm in writing what accommodations, if applicable, are granted.

Mail to:

NDHCB
1929 Russell Rd, Suite 322
Ottawa, ON K1G 4G3