

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

TITLE OF EXAMINATION: _____

DATE OF EXAMINATION: _____

NATURE OF DISABILITY: _____

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

- LARGE PRINT TEST LARGE PRINT ANSWER SHEET READER/RECORDING
- RECORDER (PERSON WHO FILLS IN ANSWERS) SEPARATE ROOM
- ADDITIONAL TIME (SPECIFY TIME NEEDED): _____
- 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.

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