FOR OFFICE USE ONLY
Application No.:
Date Received:

ACCOMMODATION REQUEST FORM FOR SAFETY AND JURISPRUDENCE TESTS

The information requested and any documentation regarding your disability and need for accommodation in taking the Safety or Jurisprudence tests will be treated confidentially and will not be shared with any outside source, other than the testing agency, without your expressed written permission. Requested accommodations are subject to the approval of the CTCMPAO.

1. CONTACT INFORMATION (confirmation will be sent by email)

Street No. & Name *(Required)* **Suite No.**

City *(Required)* **Province** *(Required)* **Country** *(Required)* **Postal Code** *(Required)*

Telephone *(Required)* **Alternate Phone** **Fax**

Email Address *(Required)*

2. EXAMINATION

For which of the following examination(s) are you requesting accommodation?

- ❑ Jurisprudence Course Test
- ❑ Safety Program Test

Examination Date(s): _____
(mm/dd/yyyy)

3. ACCOMODATION(S) FOR THE SPECIAL NEEDS REQUESTED DUE TO DISABILITY

Please check all that apply:

- ❑ Additional Time (specify additional number of minutes needed: _____)
- ❑ Other:

_____
_____
_____
_____

You are required to attach supporting documents for your special need accommodation request and submit the "Documentation of Disability-Related Needs Form".

4. SIGNATURE

Please note that the CTCMPAO might require further information from your past and/or present treating regulated health professional and will contact him/her directly if necessary. In submitting this form, you are providing your authorization to your past and/or present treating regulated health professional to disclose further information to the CTCMPAO.

_____	_____	_____
Name of Applicant (Please print)	***Signature of Applicant***	***Date of Signature*** *(mm/dd/yyyy)*

ACCOMMODATION FOR SPECIAL NEEDS
DOCUMENTATION OF DISABILITY-RELATED NEEDS

If you have a disability that requires an accommodation in taking the Safety or Jurisprudence tests, please have this section completed by an appropriate professional (i.e., physician, psychologist, rehabilitation counsellor or other professional registered with a professional regulatory body in Ontario) to certify that your disabling condition requires the requested test accommodation.

I have known _____ **since**_____
(Candidate Name) *(Date)*

in my capacity as a _____
(Professional Title)

Because of the nature of the candidate's disability

_____

_____

_____
(Description of the candidate's disability)

it is my opinion that the candidate should be accommodated by providing the following *(check all that apply)*:

- ❑ Additional Time (specify additional number of minutes needed: _____)
- ❑ Other: _____

_____

_____

_____

Name _____ **Signature**_____
(Print)

Title _____ **Date** _____

Professional Regulatory _____ **Registration No.** _____

Please email the completed form to registration@ctcmpao.on.ca

Or mail to the CTCMPAO at:

55 Commerce Valley Drive West
Suite 705
Thornhill, ON L3T 7V9