

Special Accommodation Application Form for the College of Dental Hygienists of Ontario (CDHO) QA Test

The CDHO recognizes that applicants with physical, cognitive or other special needs may require special accommodations when taking the QA Test. Registrants requesting accommodation must complete this form in advance of taking the QA Test. Please submit details of any accommodations previously provided to you in any other exam, test or academic situation. All information collected on this application, along with any supporting documentation, will be treated confidentially and will not be shared with any source without your permission.

Requested accommodations are subject to the approval of the Registrar and/or the Quality Assurance Committee. Written confirmation of granted requests for accommodations will be provided.

SECTION 1 (TO BE COMPLETED BY APPLICANT)

Contact Information

Surname:		Given Names:	
Previous Surname(s):			
Home Address (Current/Actual)	Street:	Apt/Unit #:	
	City:	Province:	Postal Code:
	Tel.:	Email:	

Accommodation Information

Nature of disability:

Please describe accommodation(s) requested:

Details of previous accommodations:

Comments:

Signature:	Date: (MM/DD/YYYY)
------------	--------------------

Supporting Documentation for Accommodation Request for the College of Dental Hygienists of Ontario (CDHO) QA Test

If you have a disability that requires an accommodation in taking the **QA Test**, this section must be completed by an appropriate professional (e.g., physician, psychologist, rehabilitation counsellor, special educator, or other professional) to certify that your condition requires the requested test accommodations.

Forms not completed by an appropriate professional will not be accepted.

SECTION 2 (TO BE COMPLETED BY APPROPRIATE PROFESSIONAL)

Applicant Information

Surname:		Given Names:	
Previous Surname(s):			
Home Address (Current/Actual)	Street:	Apt/Unit #:	
	City:	Province:	Postal Code:
	Tel.:	Email:	

Professional's Information

Title:		Surname:		Given Names:	
Business Address	Street:		Apt/Unit #:		
	City:	Province:	Postal Code:		
	Telephone:		Email:		

Declaration of Need for Accommodations

I have known	(NAME OF APPLICANT)	since	(MM/DD/YYYY)
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 professional opinion, that the candidate should be accommodated by providing			
(DESCRIPTION OF ACCOMMODATION)			
Signature:		Date: (MM/DD/YYYY)	