

TO BE COMPLETED BY THE APPLICANT

Name: _____ Registration number: _____

Address: _____

Phone number: _____

How does the nature of the disability* impact your ability to write the exam?

*You may share a specific diagnosis, but it is not required.

ACCOMMODATION REQUESTED FOR EXAM:

- Private room
- Additional time (please specify time needed): _____
- In person Reader
- Screen reader

The following Screen Readers are compatible with the exam administrator's browser, which means if you have one of them, you could potentially write the exam from your personal computer. Please indicate if you currently have on your computer:

- JAWS VoiceOver for MacOS or Narrator for Windows

Wired headphones are an additional requirement to be able to use a screen reader for the exam. Do you have or can you acquire wired headphones to use any of the three screen reader programs for the exam? Yes No

- Other (please specify):

By signing this form, I (print name): _____, authorize the release of information regarding my disability, disorder, or condition, and/or history of special accommodations as specified in this document from my Health Care Professional and/or Post-Secondary Institution.

I understand that the information concerning my case will be shared with the College of LPNs and HCAs of Alberta (CLHA), and only the type of accommodation needed will be shared with the examination administer (Yardstick).

I understand that the adjustments made for the CPNRE may not be the same as those provided in other contexts (i.e., at school). The CLHA will inform me about the type of accommodations granted.

I understand that I may be required to travel to an approved exam centre if special resources are required to support my accommodation request for a reader.

I understand that if travel is required, I am responsible for all associated travel costs.

Signature: _____

Date: _____

Please note that your application for accommodation will not be considered complete until the supporting medical information form has been received from your Health Care Professional.

3. Please indicate if the limitations and restrictions arising from the applicant's disability, disorder or medical condition would support any of the following accommodations (check all that apply).

- Private room
- Additional time to write exam (please specify time needed): _____
- In person Reader
- Screen Reader
- Other (please specify): _____

HEALTH PROFESSIONAL INFORMATION

Name (please print): _____

Professional designation: _____ Registration/License #: _____

Business address: _____

E-mail: _____

Telephone: _____

Signature: _____

Date: _____

Please ensure that this completed form, along with any other relevant information is sent directly to:

Deputy Registrar
College of LPNs and HCAs of Alberta
St. Albert Trail Place
13163 146 Street,
Edmonton, Alberta T5L 4S8

Or you may send via email to: studentservices@clha.com