

Accommodation Request Form

This form must be submitted to the NDEB Office by the registration deadline date.

Examinee Information

Family Name: _____ Given Name : _____

NDEB ID #: _____ Email address: _____

Examination/assessment (test): _____ Date: _____

Centre: _____

Have you previously received an accommodation from the NDEB? YES NO

If so, date accommodation received: _____

Accommodation provided: _____

Release of Information

I confirm that the information I provide to the NDEB is true and correct.

I authorize the NDEB to contact any medical professional who submitted supporting documentation for my accommodation.

Furthermore, I authorize _____ to supply written information to
(Name of health care provider)

the National Dental Examining Board of Canada (NDEB), regarding my ability to function; any limitations or restrictions on my ability to participate in the test; and any devices, equipment, or accommodations I require.

X _____
Signature

Date: ____/____/____
(dd) (mm) (yyyy)

Instructions for the Medical Professional

The NDEB requires that this form be completed by a licensed/registered, regulated health professional who is a specialist in the field related to the examinee's condition. *Only health information related to the accommodation request should be included.* The form must be sent directly to the NDEB office.

Test Accommodations Coordinator
The National Dental Examining Board of Canada
80 Elgin Street, 2nd Floor
Ottawa, ON K1P 6R2

Test Information

The NDEB is the organization responsible for establishing and maintaining a national standard of competence for dentists in Canada. The NDEB administers licensing examinations.

The accommodation requested cannot modify the nature and level of the competencies being assessed, or represent a fundamental alteration of the test.

Health Care Provider Information

Title: _____ Family Name: _____ Given Name : _____
Address: _____ Email address: _____
Phone number: _____

Diagnosis and Treatment Information		
Official Diagnosis:		
Is the examinee fit to participate in a test?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is this examinee fit to practice dentistry on live patients?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Brief description of diagnosis:		

Date of last visit with the examinee:

Describe how this diagnosis may impact the examinee's ability to perform under normal testing conditions:

Accommodation :

Based on your knowledge of the examinee's condition, indicate the accommodation required.

I certify that the information provided by me on this form and any attachments hereto is true and correct to the best of my knowledge.

Licence/Certification number: _____

X _____
Signature

Date: ____/____/____
(dd) (mm) (yyyy)

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