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 understand that additional documentation may be requested depending on the nature of the accommodation required.

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 ___________________________________ Date: _____/______/______
Signature (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
340 Albert Street, 12th Floor
Ottawa, ON K1R 7Y6

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 ☐	No ☐
Is this examinee fit to practice dentistry on live patients?	Y☐	N☐
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 ______________________ Date: _____/______/______ Signature (dd) (mm) (yyyy)

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