**FORM B1**

# National Dental Hygiene Certification Examination (NDHCE) Testing Accommodation – Functional Abilities Form

If you are a candidate of the National Dental Hygiene Certification Examination (NDHCE) and you have requested an accommodation on the basis of a disability (including an illness, an injury, or a medical condition) or a pregnancy/maternity-related need, please complete **Section A**, below, and bring this **Form B1** to your treating physician or other qualified health care professional.

| **SECTION A - PERSONAL INFORMATION** (Completed by candidate) | | |
|---|---|---|
| Last Name | First Name | |
| Address | | |
| City | Province | Postal Code |
| Telephone | Email | Country |

**RELEASE OF INFORMATION:**

I am a candidate of the National Dental Hygiene Certification Examination (NDHCE), which is administered by the Federation of Dental Hygiene Regulators of Canada (FDHRC). I have requested an accommodation on the basis of disability (including an illness, an injury, or a medical condition) or a pregnancy/maternity-related needs. The FDHRC requires certain information about my health and limitations in order to appropriately assess my request and manage my needs during the NDHCE process.

I, _____, hereby authorize the release of the information outlined in this form (**Form B1**) and any further documents, tests or assessment reports that are reasonably necessary to disclose. This authorization is based on the FDHRC's agreement that the information provided will be kept confidential and used only for the purposes stated above.

**Candidate's Signature :** _____ **Date:** _____

| **SECTION B** (Completed by a qualified health care professional) | | |
|---|---|---|
| **HEALTH CARE PROFESSIONAL'S DESIGNATION:** | | |
| ☐ Physician | ☐ Registered Nurse (Extended Class) | ☐ Other: _____ |
| First Name | Surname | |
| Name of Regulatory Body | License Number: | |
| Office/Organization: | | |
| City, Province and Postal Code: | | |
| Phone Number: ( ) | Fax: ( ) | |
| Date of Assessment (dd/mm/yyyy): | | |
| **I confirm that the candidate has a disability or pregnancy/maternity-related need that creates functional limitations that will affect their ability to complete the NDHCE:** | ☐ Yes | ☐ No |

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**SECTION C** (Completed by a regulated health professional)

**1.** How long has the candidate been in your care? _____

**2.** If the accommodation request is based on a **disability**, what type of disability is it (select all that apply)?

☐ Cognitive ☐ Psychological ☐ Physical ☐ N/A (pregnancy/maternity-related need)

**3.** ☐ I diagnosed the candidate's disability or confirmed their pregnancy/maternity-related needs; **OR**,
☐ I did not diagnose the candidate's disability. Did you confirm diagnosis? Yes / No (circle one)

**4.** Which of the following did you employ in making or confirming the diagnosis of the disability or confirming the candidate's pregnancy/maternity needs? (Select all that apply and attach copies of any relevant tests/reports:)

☐ specific medical tests ☐ medical observation ☐ self-reporting by the candidate ☐ another method

Please specify: _____

_____

_____

_____

**5.** The NDHCE is a computer-based multiple choice exam delivered over 4 hours (two 2-hour parts separated by a short (15 min) break) either in a testing centre or virtually proctored. Explain **why** the candidate requires an accommodation and **how** the candidate's disability or pregnancy/maternity-related needs will impact their ability to complete the NDHCE under standard testing conditions. Briefly describe the candidate's disability or pregnancy/maternity-related need(s) (you **do not** need to disclose diagnosis).:

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**6.** List and describe **what** accommodations the candidate needs. Please be as **specific** as possible (e.g., what are the candidate's limitations/restrictions, indicate right and/or left, where necessary. Where a candidate is unable to sit/stand for extended periods of time, indicate the maximum duration etc.) If the candidate requires adaptive software, technology, or other physical resources please specify the item requested. If the candidate requires additional writing time, please specify **the exact amount of additional time required** (e.g. 15 minutes or 1 hour per part). Requests for a span of time (e.g. 1-2 hours) or unlimited time will not be granted. If the candidate requires additional breaks, please specify how many additional breaks and how long is required for a break (e.g. One 5-minute break per part of the exam).

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## SECTION E – DECLARATION

I confirm that the information I have provided is truthful and accurate to the best of my knowledge and is within my scope of practice.

**Printed Name:** _____

**Signature:** _____

**Date:** _____

**Medical Stamp**

**Directly forward the completed Form B1 and any attachments to info@fdhrc-forhdc.ca and please email a copy to the candidate. When using fax, please send to 613-260-8511.**

**If you have any questions or concerns with the content of Form B1, please send a detailed email message to info@fdhrc-forhdc.ca.**