THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

REQUEST FOR TEST ACCOMMODATION

Candidate information:	Date:
Name:	CFPC Member ID:
Email:	Telephone:
Did you indicate on the exam application that you require testing accommodation? ☐ yes ☐ no	

Examination information:

☐ Certification Examination in Family Medicine (CCFP) ☐ written ☐ oral

☐ Examination of Added Competence in Emergency Medicine (CCFP(EM)) ☐ written ☐ oral

Accommodations information:

Type of accommodations
☐ Additional BREAK TIME – specify amount in minutes:
☐ PRIVATE TEST ROOM ☐ SECLUDED BREAK AREA ☐ ELECTRICAL OUTLET
☐ EQUIPMENT, FOOD OR MEDICATION – specify: (i.e., wheelchair access, ergonomic set-up, blood glucose monitor)
☐ RELIGIOUS ACCOMMODATION – indicate day unable to test:
☐ Additional TESTING TIME – specify amount: ☐ 25% ☐ 33% ☐ 50% ☐ 100% Additional testing time is for: ☐ writing ☐ reading instructions ☐ patient encounters
☐ OTHER accommodation not listed above – specify:
Reason for accommodation:
Other pertinent details:
Supporting documentation:
Accommodations **NOT** requiring additional testing time and/or private testing space: ☐ Original letter on office letterhead signed by fully licensed family physician or appropriate licensed health care provider, identifying and confirming the need for such accommodations. Letter must not be from a relative or spouse.
Accommodations **REQUIRING** additional testing time and/or private testing space: ☐ Original letter on office letterhead signed by fully licensed practicing physician, clinical psychologist or other appropriate licensed health care provider, identifying and confirming all details as outlined in the CFPC Policy on Test Accommodations. ☐ Current contact information for each professional expert providing supporting documentation ☐ Copy of previously awarded test accommodations by a university or other medical educational program (if applicable)
Accommodation for lactation: ☐ A separate, signed personal attestation OR a signed letter on office letterhead from a personal healthcare professional such as a family physician, lactation consultant or doula confirming that the candidate will be nursing at the time of the examination.

Certification and Authorization:

I hereby certify that, to the best of my knowledge, the information recorded on this request form is true and accurate. I authorize CFPC to contact the any of the organizations or professionals who have provided documentation in support of my request to provide further information or clarity with respect to the accommodations requested.

Signature: _____ Date: _____

Submit this form and supporting documentation to: ccfpexam@cfpc.ca
2630 Skymark Avenue, Mississauga, ON L4W 5A4