

Candidate information:		Date:
Name:	CFPC Member ID:	
Email:	Telephone:	
Did you indicate on the exam application that you require testing accommodation? <input type="checkbox"/> yes <input type="checkbox"/> 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
<input type="checkbox"/> Additional BREAK TIME – specify amount in minutes:
<input type="checkbox"/> PRIVATE TEST ROOM <input type="checkbox"/> SECLUDED BREAK AREA <input type="checkbox"/> ELECTRICAL OUTLET
<input type="checkbox"/> EQUIPMENT, FOOD OR MEDICATION – specify: (i.e., wheelchair access, ergonomic set-up, blood glucose monitor)
<input type="checkbox"/> RELIGIOUS ACCOMMODATION – indicate day unable to test:
<input type="checkbox"/> Additional TESTING TIME – specify amount: <input type="checkbox"/> 25% <input type="checkbox"/> 33% <input type="checkbox"/> 50% <input type="checkbox"/> 100%
Additional testing time is for: <input type="checkbox"/> writing <input type="checkbox"/> reading instructions <input type="checkbox"/> patient encounters
<input type="checkbox"/> OTHER accommodation not listed above – specify:
Reason for accommodation:
Other pertinent details:
Supporting documentation:
Accommodations <b>NOT</b> requiring additional testing time and/or private testing space: <input type="checkbox"/> 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 <b>REQUIRING</b> additional testing time and/or private testing space: <input type="checkbox"/> 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 <a href="#">CFPC Policy on Test Accommodations</a> . <input type="checkbox"/> Current contact information for each professional expert providing supporting documentation <input type="checkbox"/> Copy of previously awarded test accommodations by a university or other medical educational program (if applicable)
Accommodation for lactation: <input type="checkbox"/> 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: \_\_\_\_\_