

CANDIDATE APPLICATION FORM

The information requested and any documentation regarding your disability and need for accommodation in taking the registration examination will be treated confidentially and will not be shared with any outside source, other the testing agency and the examination invigilator. Requested accommodations are subject to the approval of the College.

PERSONAL INFORMATION

Legal Last Name		Legal First Name		Legal Middle Name (if any)	
Date of Birth	MM	DD	YYYY	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Registration/Application No.

EXAMINATION

Intended Examination Write Date (MM/DD/YYYY): _____

ACCOMMODATION(S) FOR SPECIAL NEEDS REQUESTED

Check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Separate Room | <input type="checkbox"/> Large Print Exam |
| <input type="checkbox"/> Reader | <input type="checkbox"/> Large Print Answer Sheet |
| <input type="checkbox"/> Recorder | <input type="checkbox"/> Kurzweil Format |
| <input type="checkbox"/> Additional Time | |

Specify additional number of minutes needed: _____

Other:

APPLICANT'S SIGNATURE

I, _____, declare that all the information and statements made in or submitted with this application are true, complete and correct, and I make this declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath. I also understand that misstatements or omissions of material facts may be cause for denial of this application, or for suspension or revocation of registration.

By signing this application, I authorize the College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia (CTCMA) to collect the personal information that I have provided in this application form and to use that personal information for the purposes of processing my application for the purposes of registration under the *Health Professions Act*, RSBC 1996, c. 183 and I consent to the disclosure of that personal information to the testing agency and the examination invigilator for the purposes of administrating the examination, processing my examination results and providing information regarding my examination results back to the CTCMA.

_____ Signature of Applicant	_____ Date
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DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a disability that requires an accommodation in taking the registration examination, please have this section completed by an appropriate professional (e.g., physician, psychologist, rehabilitation counselor, special educator, or other professional registered with a professional regulatory body) to certify that your disabling condition requires the requested test accommodation.

I have known _____ since _____
(Candidate Name) (Date)

in my capacity as a _____
(Professional Title)

Because of the nature of the candidate's disability: _____

(description of the candidate's disability)

it is my opinion that the candidate should be accommodated by providing the following (check all that apply):

- Separate Room
- Large Print Exam
- Reader
- Large Print Answer Sheet
- Recorder
- Kurzweil Format

Additional Time:

Specify additional number of minutes needed: _____

Other:

_____ Name	_____ Professional Regulatory Body
_____ Professional Title	_____ Registration/License No.
_____ Signature	_____ Date