Form 1 - Registration Examination - Request for Accommodation

TO BE COMPLETED BY THE APPLICANT

Note to the Applicant: The College of Chiropodists of Ontario collects this information for the purpose of responding to your accommodation request. However, any information provided may be considered for the purpose of determining whether you suffer from any physical or mental condition or disorder that could affect your ability to practice chiropody in a safe manner.

Name ____

Address ____

Phone number ____

E-mail address ____

Institution where you received your chiropody education

____

Please describe the accommodation(s) you are requesting for either or both components of the examination.

Written component

____

____

Objective Structured Clinical Examination (OSCE) component

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Please explain the reason for your accommodation(s) request

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Did you receive the requested accommodation(s) during your chiropody education? Please explain why or why not.

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If the request relates to a disability, you will be required to submit supporting medical documentation, preferably in the Form 1A attached.

Supporting Documentation attached:

Yes ____________

No_____________

If you have not attached any supporting documentation, please explain why not.
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Thank you for your application. We will make our best efforts to advise you within 15 days if the accommodation has been granted. If your request is complex, or you have not provided the appropriate supporting documentation we may require more time to process your request

Form 1A - Supplementary Medical Information- Request for Accommodation

TO BE COMPLETED BY THE HEALTH PROFESSIONAL

Note to the Applicant: The College of Chiropodists of Ontario collects this information for the purpose of responding to your accommodation request. However, any information provided may be considered for the purpose of determining whether you suffer from any physical or mental condition or disorder that could affect your ability to practice chiropody in a safe manner.

Health Professional Information

Name_________________________________ Professional Designation________________

Mailing Address ____

Phone Number __________________________Fax Number ________________________

Information Regarding the Applicant

How long have you been treating the applicant?_____________________________________

Please briefly describe the disability/ies for which the applicant requires accommodation(s)

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For each disability, please state when (1) this disability was first diagnosed (2) any functional limitations resulting from the disability and (3) its expected prognosis.

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As a result of the disability/ies, please state what accommodation(s) the applicant requires on the registration examination and why.

Written component

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Objective Structured Clinical Examination (OSCE)

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Signature of Health Professional: ________________________ Date: ____________________

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