Candidate Application for Custom Testing Arrangements

Part A: Must be completed by the Exam Candidate.

CRNA reviews applications and recommends reasonable and appropriate test accommodations for individuals with documented disabilities and a demonstrated need. The information below and any related documentation regarding this request will be treated confidentially by CRNA.

Full Name		**File number**	
Email			
Name of the Exam			

1. Please identify why you are applying for custom testing arrangements, including a description of the diagnosis which prevents you from writing the exam in the usual method or environment.

All candidates have up to six hours to complete the exam, including an optional break after 2 hours of testing, a second optional break after 3.5 hours of testing, and unscheduled breaks as required.

2. Please select the type of accommodation you are requesting (select all that apply).

☐ Separate Room

☐ Extra time (please specify): ☐ 2 hours ☐ 3 hours ☐ 6 hours (written over two days)

☐ Adjustable contrast ☐ Adjustable font size

☐ Assistive personnel (readers, sign language interpreters)

☐ Other (please specify): _____

3. Please provide a description of past testing accommodations granted, including those provided throughout your nursing program.

_____ _____

Signature *Date*

11120 178 Street, Edmonton, AB, T5S 1P2 1 (800) 252-9392 crna@nurses.ab.ca

CRNA

Part B: Must be completed by a qualified health professional.

CRNA reviews applications and recommends reasonable and appropriate test accommodations for individuals with documented disabilities and a demonstrated need. The information below and any related documentation regarding this request will be treated confidentially by CRNA.

Please review Side A of this form, complete the information below, and forward both sides of this form directly to CRNA (contact information below).

1. I have known this candidate since: _____ in my capacity as _____
(date) *(professional designation)*

2. Please indicate the approximate date when the disability was first diagnosed and/or identified.

3. Please provide a brief history and description of the disability, including the functional limitations which would impact the candidate's ability to take the exam in the usual method and/or environment. Please attach a separate letter if needed.

4. Please confirm that the request(s) made by the applicant is/are necessary and appropriate, or recommend alternatives.

Full Name	
Practise ID	
Signature	
Email	
Date	
Full Address & Name of Clinic	

Please submit form by email to registration@nurses.ab.ca or fax to 780.452.3276.