



Testing Accommodations
Documentation of Disability-Related Needs Form

If you have a disability that requires an accommodation to take the registration examination (NCLEX), please have this section completed by a qualified health professional (e.g., Physician, psychologist) to certify that you require the accommodation.

Examples of documentation completed by the qualified health professional that would support the accommodations request include:

- Identification of the disability and/or diagnosis;
- The approximate date when the disability was first diagnosed and/or identified;
- A brief history and description of the disability;
- Identification of the tests and/or protocols used to confirm the diagnosis;
- A description of past accommodations granted for the disability;
- The nature/type of the accommodation currently being requested;
- An explanation why the specific accommodation is needed;
- A legible signature, title and qualifications, and contact information (telephone, e-mail) of the qualified health professional; and
- History of accommodations provided to the candidate in testing situations during her/his nursing program.

Please submit the supporting documentation along with this form directly to the Nurses Association of New Brunswick by fax 506-459-2838 or by email at nanbregistration@nanb.nb.ca.

I have known _____ Since _____
(name of candidate) (date)

in my capacity as a _____

Due to the nature of the candidate's disability _____
(description of the candidate's disability)

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

- | | |
|---|---|
| <input type="checkbox"/> Separate room | <input type="checkbox"/> Adjustable contrast |
| <input type="checkbox"/> Separate room and reader | <input type="checkbox"/> Font size |
| <input type="checkbox"/> Separate room and recorder | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Additional time (please specify time needed) _____ | |

Comments by the qualified professional completing this form

Name: _____	Telephone: _____
Title _____	E-mail: _____
Signature: _____	Date: _____

Nurses Association of New Brunswick
L'Association des infirmières et infirmiers du Nouveau-Brunswick

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