Ordre des infirmières et infirmiers du Québec

PROFESSIONAL EXAMINATION

Medical certificate for request for accommodation measures

Office of the Admissions and Registrar

IDENTIFICATION OF CANDIDATE

Surname: _____ Permanent code: _____

First name: _____ **Or** File number: _____

Exam date: _____ MM/DD/YYYY Date of birth: _____ MM/DD/YYYY

IMPORTANT INFORMATION

The diagnosis must be completed by a health-care professional or an expert in education

To have this request for accommodation considered, it is necessary to **demonstrate that the state of health** of the person covered by this certificate entails **functional limitations** resulting from **a physical or mental impairment** that **limits the person's ability to pass the Order's professional examination**

All of the information provided will be treated in the strictest confidentiality. The candidate is responsible for any and all costs associated with the production of this certificate.

SECTION 1 | State of health

Please state the specific diagnosis related to the functional limitations:

_____ ○ Permanent ○ Temporary

SECTION 2 | Recommended accommodation measures

Local:

☐ no special room

☐ with reduced environmental stimulation

Extra time:

☐ none

☐ + 33 %

☐ + 50 %

Other measures (please specify):

_____

SECTION 3 | Details regarding the limitations and recommended accommodation measures

Please describe: **a)** the person's functional limitations and **b)** the effect of the limitations on the person's ability to pass the examination:

a) limitations: **b)** effect of limitations on ability to pass the exam:

_____

_____

_____

_____

_____

SECTION 4 | Signature of health-care professional

☐ I certify that these accommodation measures are necessary in order for the candidate to pass the examination.

Surname, first name: _____ Email: _____

Title: _____ Telephone: _____

Institution: _____ Postal code: _____

Signature / # Permit: _____ Date: _____ MM/DD/YYYY

CANDIDATE'S CONSENT AND SIGNATURE

☐ I have read all of the above information and I understand that the information will be forwarded to the Request Committee for the purpose of studying my request for accommodation measures.

☐ I authorize the OIIQ to communicate with the above-mentioned health-care professional regarding the information provided in this certificate.

Signature: _____ Date: _____ MM/DD/YYYY