Ordre des infirmières et infirmiers du Québec

PROFESSIONAL EXAMINATION

Health certificate in support of a request for accommodation

Office of the Admissions and Registrar

CANDIDATE INFORMATION

Name: _____ Permanent code: _____

First name: _____ **OR** File number: _____

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

Reminder: You are responsible for informing the OIIQ of any changes to your contact information.

IMPORTANT INFORMATION

This health certificate must be completed by a qualified healthcare professional or the academic accommodations expert who oversaw the accommodations provided during the candidate's training.

To be considered, this request for accommodation must **demonstrate the existence of functional limitations resulting from a physical or mental impairment** that restrict the candidate's **ability to successfully complete the OIIQ's professional examination**.

All information provided will be handled in a strictly confidential manner. The candidate is responsible for any costs associated with the production of this certificate.

SECTION 1 | Medical condition

Please indicate the candidate's diagnosed functional limitations:

_____ ◯ Permanent ◯ Temporary

SECTION 2 | Recommended accommodation

☐ **Room with reduced stimulation** (see definition here)

☐ **Other** – please specify (e.g., equipment, additional time if more than 50%, text-to-speech software, privacy screen, noise-cancelling headphones, exam room features):

_____

SECTION 3 | Limitations and recommended accommodation

Please describe: **a)** the candidate's functional limitations and **b)** the impact of the limitations on the candidate's ability to successfully complete the examination:

a) Limitations:	**b)** Impact on the ability to successfully complete the examination:

SECTION 4 | Signature of healthcare professional or academic accommodations expert

☐ I certify that the candidate requires the accommodation requested to successfully complete the examination.

Name, first name: _____ Email: _____

Title: _____ Telephone: _____ 123-123-1234

Institution: _____ Postal code: _____

Signature: _____ Date: _____ DD/MM/YYYY

Permit number: _____

CANDIDATE CONSENT AND SIGNATURE

☐ I have read the above information and I understand that this information may be disclosed to the Applications Committee for the purposes of reviewing my request for accommodation.

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

Signature: _____ Date: _____ DD/MM/YYYY