ACCOMMODATION REQUEST FORM

Pursuant to the CBV Institute (the "Institute") Accommodation Policy for Registered Students and MQE Candidates (the "Policy"), any Applicant (as defined in the Policy) with a disability who wishes to request an academic accommodation must complete this Accommodation Request Form and comply with all timelines set out in the Policy.

This Accommodation Request Form will only be considered valid for a maximum of three (3) years after the date which the qualified health care provider signed this Form. The Institute may request further information and/or supporting documentation to assess the Applicant's needs in order to provide appropriate academic accommodation, in accordance with the Policy.

All information and/or supporting documentation is required to be provided in English or French.

SECTION 1 – APPLICANT FORM

This Section must be completed entirely by the Applicant. If seeking ongoing academic accommodation which will impact multiple examinations, please indicate the next applicable examination in Section 1.2.

Section 1.1 – Applicant Information			
Full Name:		Student ID:	
Email Address:		Phone Number:	
Section 1.2 – Examination Information			
Exam:		Exam Date:	
Have you previously been granted an accommodation for an examination by the Institute? Yes ☐ No ☐ If yes, specify the year and exam:			

Have you previously been granted an accommodation for an examination by another accredited professional body? (i.e. CPA Canada, CFA Institute, etc.)

Yes ☐ No ☐ If yes, specify the year, professional body, and exam:

Have you previously been denied academic accommodation for an examination by the Institute or another accredited professional body?

Yes ☐ No ☐ If yes, specify the year, professional body, and exam:

Section 1.3 – Nature of Disability

What is the nature of your disability and/or impairment?	

Section 1.5 – Applicant Declaration

The Institute is dedicated to protecting your privacy and personal information. The information requested on this form is collected, used, and disclosed in accordance with applicable federal and provincial laws and the Institute's Policy. This information will be shared and reviewed only as necessary and as specified in the Policy to determine eligibility for accommodations and to implement any approved accommodations.

I certify that the information provided in this form is accurate and complete. I hereby grant the Institute permission to share, as needed, all pertinent details related to my accommodation request, including, but not limited to:

- this Accommodation Request Form and any supporting documents;
- all relevant statements and documentation submitted by qualified/licensed professionals; and
- any additional documentation requested and received by the Institute.

I authorize the regulated health care provider below to provide the information in this form and specifically as set out in Section 2 for the purpose of an accommodation request with the Institute. I understand that all the aforementioned information may be distributed and reviewed by the Institute's Director of Education or their delegate(s) for the purpose of determining accommodations to be granted, if any. I understand that information necessary to facilitate the accommodation, including my name, exam, and the accommodation, will be provided to relevant staff.

Date:	Signature:

SECTION 2 – MEDICAL PRACTITIONER FORM

This Section must be completed in its entirety by a regulated health care professional located in the student's country of residence. A regulated health care professional is a professional who is licensed to provide a diagnosis or comprehensively assess and manage the disability or health condition in the course of providing health care services. The regulated health care provider is required to fill this Section out entirely; the Applicant is not to pre-populate this Section.

2.1 – Licensed Medical Practitioner's Information	
Professional's name:	
Name of regulatory body affiliated with:	
Designation:	
License Number:	
Address:	
Phone Number:	
Please outline your qualifications and your professional relationship with the Applicant that enable you to recommend accommodations for them.	
2.2 - Nature of Disability:	
(OPTIONAL) Diagnosis	
Did you diagnose the condition? Yes ☐ No ☐ If yes, when?	
If you did not diagnose this condition, did you confirm this condition? (leave blank if answer above is yes) Yes ☐ No ☐ If yes, when?	

Please describe the nature of the disability and/or impairment:
Please explain how the Applicant is impacted by the disability and/or impairment:
Please provide the date of your last treatment or consultation with the Applicant:
Please describe how the Applicant's disability and/or impairment affects their performance in online testing environments. Specifically, outline the functional limitations related to the Applicant's condition and explain how these limitations impact their ability to complete online, proctored examinations. General complaints or symptoms do not constitute evidence of functional limitations.
If applicable, please advise if the Applicant has been prescribed any medications or course of treatment that may mitigate or lessen the symptoms of their condition and if so, whether this been taken into account in your assessment of the accommodations requested below:

Based on your knowledge of the Applicant's condition, which of the following accommodations do you recommend? (please include all that apply):	
Additional time	_____ minutes per hour of exam
Timed rest breaks	_____ minutes per hour of exam
Other (Specify)	
What is the anticipated duration of the disability (i.e. less than one (1) year, more than one (1) year), or other).	

2.3 - Certification

I affirm that the information I have provided on this form and any attached documents is accurate and complete to the best of my knowledge. I confirm that I have personally completed this form. I confirm that I have no personal relationship with the Applicant.	
Date:	Signature: