ALBERTA PROVINCIAL HEALTH CARE AIDE (HCA) EXAM ACCOMMODATION REQUEST FORM

TO BE COMPLETED BY THE APPLICANT(HCA):

Full Name: ______________________________ Directory number: _________________

Address: ____

Phone number: _______________________

Nature of disability*: ____

Note* *when completing this form, disclose only information necessary to meet the purpose of the form. Typically, it is not necessary to provide specific diagnosis. Provide information on the general nature of the disability, disorder or condition.*

ACCOMMODATION REQUESTED FOR EXAM

□ Additional time (please specify time needed): ____________________________
□ Reader
□ Other (please specify): ____

____

Additional comments:____

____

____

____

By signing this form, I (print name)______________________________, authorize the release of information regarding my disability, disorder or condition and/or history of special accommodations as specified in in this document from my Health Care Professional and/or Post-Secondary Institution.

I understand that the information concerning my case will be shared with the Alberta Health Care Aide Directory and the examination administer (Yardstick).

I understand that the adjustments made for the Alberta Provincial Exam may not be the same as those provided in other contexts (i.e. at school). The Directory will inform me about the type of accommodations granted.

I understand that I may be required to travel to an approved exam centre if special resources are required to support my accommodation request for a reader.

I understand that if travel is required, I am responsible for all associated travel costs.

Signature: _________________________ Date: _________________________

Revised Aug 12, 2020

ALBERTA PROVINCIAL HEALTH CARE AIDE (HCA) EXAM
ACCOMMODATION REQUEST FORM

EXAM ACCOMMODATION REQUEST -
SUPPORTING MEDICAL INFORMATION FORM

TO BE COMPLETED BY THE HEALTH PROFESSIONAL:

I have known (applicant) ________________________ since (date) ________________ _in my capacity as (professional title) ____ _.

1. Provide general nature of disability, disorder, or condition, including date that the disability was initially diagnose. (**Note*** *When completing this form, disclose only information necessary to meet the purpose of the form. Typically, it is not necessary to provide specific diagnosis, provide information on the general nature of the disability, disorder or condition.)*

   ____

   ____

   ____

2. Describe the limitations and restrictions on the applicant arising from the applicants' disability, disorder, or medical condition:

   ____

   ____

   ____

3. Please indicate if the limitations and restrictions arising from the applicants' disability, disorder or medical condition would support any of the following accommodations (*check all that apply*):

   □ Additional time to write exam (please specify time needed): ____________________________
   □ Reader
   □ Other (please specify): ____

4. Is the applicant following a recommended treatment program? Is there any impact on testing or exam performance?

   ____

   ____

   ____

Alberta Health Care Aide Directory

TO BE COMPLETED BY THE POST-SECONDARY INSTITUTION:

5. Describe any past accommodation(s) granted to the applicant for their disability, disorder or condition, including accommodations provided to the applicant in testing situations during their education program:

   ____

   ____

   ____

HEALTH PROFESSIONAL INFORMATION

Name (please print): ________________________ Professional designation: ________________________

Business address: ____

____

E-mail: ___________________________ Telephone: ________________________

By signing this form, I (print name) ___________________________________certify all information is true and correct to the best of my knowledge

Signature: ________________________ Date: _____________________________

POST-SECONDARY INSTITUTION INFORMATION

Institution Name (please print): ____

Institution address:

____

Signatory Name (please print): ____

Signatory Title (please print): ____

E-mail: ___________________________ Telephone: _______________________

By signing this form, I (print name) ___________________________________certify all information is true and correct to the best of my knowledge

Signature: ________________________ Date: __________________________

This form *must* be completed in its entirety. Please ensure that the health professional or post-secondary institution submits this completed form, along with any other relevant information directly to info@albertahcadirectory.com or mailed to:

Alberta Health Care Aide Directory
College of Licensed Practical Nurses of Alberta
St. Albert Trail Place
13163 146 Street, Edmonton, Alberta T5L 4S8