FORM B2

Canadian Performance Exam in Dental Hygiene (CPEDH)
Testing Accommodation – Functional Abilities Form

If you are a candidate of the Canadian Performance Exam in Dental Hygiene (CPEDH) and you have requested an accommodation on the basis of a disability (including an illness, an injury, or a medical condition) or a pregnancy/maternity-related need, please complete **Section A**, below, and bring this **Form B2** to your treating physician or other qualified health care professional.

SECTION A - PERSONAL INFORMATION (to be completed by candidate)		
Last Name	First Name	
Address		
City	Province	Postal Code
Telephone	Email	Country

RELEASE OF INFORMATION:

I am a candidate of the Canadian Performance Exam in Dental Hygiene (CPEDH), which is administered by the Federation of Dental Hygiene Regulators of Canada (FDHRC). I have requested an accommodation on the basis of disability (including an illness, an injury, or a medical condition) or a pregnancy/maternity-related needs. The FDHRC requires certain information about my health and limitations in order to appropriately assess my request and manage my needs during the CPEDH process.

I, _____, hereby authorize the release of the information outlined in this form (**Form B2**) and any further documents, tests or assessment reports that are reasonably necessary to disclose. This authorization is based on the FDHRC's agreement that the information provided will be kept confidential and used only for the purposes stated above.

Candidate's Signature : _____ **Date:** _____

SECTION B (to be completed by a qualified health care professional)		
HEALTH CARE PROFESSIONAL'S DESIGNATION:		
☐ Physician	☐ Registered Nurse (Extended Class)	☐ Other: _____
First Name	Surname	
Name of Regulatory Body	License Number:	
Office/Organization:		
City, Province and Postal Code:		
Phone Number: ( )	Fax: ( )	
Date of Assessment (dd/mm/yyyy):		
I confirm that the candidate has a disability or pregnancy/maternity-related need that creates functional limitations that will affect their ability to complete the CPEDH:	☐ Yes	☐ No

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SECTION C (to be completed by a qualified health care professional)

1. How long has the candidate been in your care?: _____

2. If the accommodation request is based on a **disability**, what type of disability is it (select all that apply)?

☐ Cognitive ☐ Psychological ☐ Physical ☐ N/A (pregnancy/maternity-related need)

3. ☐ I diagnosed the candidate's disability or confirmed their pregnancy/maternity-related needs; **OR**,
☐ I did not diagnose the candidate's disability. Did you confirm diagnosis? Yes / No (circle one)

4. Which of the following did you employ in making or confirming the diagnosis of the disability or confirming the candidate's pregnancy/maternity needs? (Select all that apply and attach copies of any relevant tests/reports:)

☐ specific medical tests ☐ medical observation ☐ self-reporting by the candidate ☐ another method

Please specify: _____

5. The CPEDH is a two-part performance-based assessment. Part 1 of the CPEDH is approximately a three-hour assessment involving seven standardized simulations. Part 2 is approximately a four-hour assessment of three clinical simulations with actual clients. In both parts, the candidate is given instructions (written in Part 1, oral in Part 2) and expected to perform tasks or manage the situation accordingly.

Explain **why** the candidate requires an accommodation and **how** the candidate's disability or pregnancy/maternity-related needs will impact their ability to complete the CPEDH under standard testing conditions. Briefly describe the candidate's disability or pregnancy/maternity-related need(s) (you **do not** need to disclose diagnosis).

6. List and describe **what** accommodations the candidate needs. Please be as **specific** as possible (e.g. what are the candidate's limitations/restrictions, indicate right and/or left, where necessary. Where a candidate is unable to sit/stand for extended periods of time, indicate the maximum duration etc.):

FORM B2

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SECTION E – DECLARATION (to be completed by a qualified health care professional)

I confirm that the information I have provided is truthful and accurate to the best of my knowledge and is within my scope of practice.

Printed Name: _____

Signature: _____

Date: _____

Medical Stamp

Directly forward the completed Form B2 and any attachments to exam@fdhrc.ca and please email a copy to the candidate. When using fax, please send to 613-260-8511.

If you have any questions or concerns with the content of Form B2, please send a detailed e-mail message to exam@fdhrc.ca.