DURHAM COLLEGE
SUCCESS MATTERS

LLQP Accommodation Request Form
Corporate Training Services

For more information or to request alternate formats of this form for accessibility, please contact LLQP.Admin@durhamcollege.ca.

Please submit the completed form to LLQP.Admin@durhamcollege.ca, we will reach out to confirm your accommodation upon receipt of the completed form and follow up with next steps.

Part 1: Candidate Information

First Name: _____ Last Name: _____

CIPR #: _____ Phone Number: _____

Email: _____

Part 2: Exam Format & Location

Please indicate your preferred exam format and location.

- ☐ Online
- ☐ In Person (Paper)

If selecting In Person, please provide your preferred exam location:

_____

Part 3: Diagnosis and Impact

This section must be completed by the accredited diagnosing health professional, such as a Physician, Neurologist, Audiologist, Ophthalmologist, Psychologist, Psychiatrist, or other medical specialist who is authorized to provide a clinical diagnosis.

Please identify the candidate's diagnosis:

- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Autism Spectrum Disorder
- ☐ Acquired Brain Injury
- ☐ Visually Impaired / Low Vision
- ☐ Deaf / Hard of Hearing
- ☐ Medical / Chronic illness
- ☐ Mobility / Functional Impairment
- ☐ Mental Health
- ☐ Other: _____

Please select one of the following statements that apply to the candidate's disability in a testing environment:

☐ **Permanent** It is expected that the condition will remain with the candidate and will require management over the course of their normal natural life.

☐ **Temporary** It is expected that the condition will be short lived and require short term management.

What is the current impact of diagnosis(es) in the testing environment?

Based on the identified diagnosis(es), what accommodations would you recommend to promote the candidate's success in a testing environment? Please see guide below and check all that apply or identify any other recommendations in the 'Other' section.

☐ Extra time for exams (max. 2x)

☐ Spacing between exams

☐ Modifications to the test environment:

☐ Assistive Technology:

☐ Other:

Part 4: Other Comments

Please indicate if there is any other relevant information that would be helpful to share to ensure this candidate is support appropriately.

Part 5: Certificate of Accredited Diagnosing Health Care Provider

First Name: _____ Last Name: _____

Specialty (If applicable): _____

Phone Number: _____ License Number: _____

Signature: _____ Date (yyyy-mm-dd): _____

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