COPR OCRP
Canadian Organization of Paramedic Regulators
Organisation Canadienne des Régulateurs Paramédicaux

Examination Disability Information Form

Name of Applicant	
QUALIFIED REGULATED HEALTH PROFESSIONAL	
Name of Qualified Regulated Health Professional	**Name of Applicable Regulatory Body**
Registration Number	**Address (including country)**
Email	**Telephone**
NATURE OF DISABILITY	

COPR considers a "disability" to mean:
Any degree of physical disability, infirmity, malformation or disfigurement, including:

- epilepsy;
- any degree of paralysis;
- amputation;
- lack of physical coordination;
- blindness or visual impediment;
- deafness or hearing impediment;
- muteness or speech impediment; or
- physical reliance on a service animal, wheelchair or other remedial appliance or device; or Any of the following disabilities:
- a developmental or intellectual disability or impairment;
- a learning disability, or a dysfunction in one or more of the processes involved in the comprehension or use of symbols or spoken language; or
- mental disorder.

In your opinion, is the Applicant disabled within the meaning of the definition above? Yes ☐ No ☐

If "Yes", please describe the general nature of the disability:

How does the disability impact the Applicant's ability to fulfill COPR's Entry to Practice Examination?

What specific accommodations do you recommend? **Please be specific for all accommodations. For example, if extra time is required, please specify the amount of extra time (15 minutes, ½ hour, 1 hour, time and a half, double time, etc.) that is required to provide the applicant with a fair testing environment to meet the needs of his/her disability.**
Please explain how each recommended accommodation will mitigate the effect of the Applicant's disability on the Applicant's ability to fulfill COPR's Entry to Practice Examination.
Please describe your professional qualifications relevant to your ability to assess the Applicant and recommend accommodations. How long has the Applicant been in your care? Is your assessment of the Applicant current (within the last year)? If your assessment of the Applicant is not current (i.e. not within the last year), please describe whether the assessment is still valid and why. Is the above information based on your examination or management of the Applicant? Do you have any additional comments that are relevant to the accommodation request?

CERTIFICATION BY QUALIFIED REGULATED HEALTH PROFESSIONAL	
I hereby certify that: • The Applicant has authorized and directed me to provide this information to COPR; • The Applicant has further authorized and directed me to supply additional documentation and information, if required to COPR related to the Applicant's request for accommodation; • I have personally examined/assessed the Applicant; • I provide(d) health care services to the Applicant in respect of the Applicant's disability; • I have specific training and expertise with respect to the disability for which accommodation is being requested by the Applicant; • I am registered, certified or licensed to practice in my field; and • The documentation and information I have provided is, to the best of my knowledge, true, accurate and complete.	
Signature of Qualified Regulated Health Professional	**Date**
Medical office stamp	

Instructions to Examination Candidates: Upload this form to your COPR Examination Application via the COPR Applicant Portal by the application deadline.