

### CANDIDATE APPLICATION FORM

The information requested and any documentation regarding your disability and need for accommodation in taking the registration examination will be treated confidentially and will not be shared with any outside source, other the testing agency, Yardstick Software Inc. Requested accommodations are subject to the approval of the College.

**Accommodation for Special Needs Request Deadline: August 1, 2018.**

### PERSONAL INFORMATION

Legal Last Name	Legal First Name	Legal Middle Name (if any)
Previous Last Name <i>(only if different from legal name)</i>	Previous First Name <i>(only if different from legal name)</i>	Previous Middle Name <i>(only if different from legal name)</i>

I am an existing registrant (including student registrant) of CTCMA.

R.Ac    R.TCM.H.    Student Registrant

Registration Number: \_\_\_\_\_

I have previously applied for CTCMA registration/examination.

My Application Number was \_\_\_\_\_

I have never applied for CTCMA registration/examination. This is my first application.

Date of Birth				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Office Use Only
	MM	DD	YYYY		

### EMAIL ADDRESS

Email (Mandatory):

**Please log-in to the Member Portal of CTCMA website to update your mailing address. It is required for sending out your examination result notification letter.**

### EXAMINATION

**Acupuncturists:**

- Written Examination
- Clinical Examination

**Herbalists:**

- Written Examination
- Clinical Examination

**TCM Practitioners:**

- Written Examination
- Clinical Examination

Examination Date (MM/DD/YYYY): \_\_\_\_\_

### ACCOMMODATION(S) FOR SPECIAL NEEDS REQUESTED

**Check all that apply:**

- Separate Room
- Reader
- Recorder
- Additional Time:
- Large Print Exam
- Large Print Answer Sheet
- Kurzweil Format

Specify additional number of minutes requested: \_\_\_\_\_

- Other:

\_\_\_\_\_  
\_\_\_\_\_

### APPLICANT'S SIGNATURE

I, \_\_\_\_\_, declare that all the information and statements made in or submitted with this application are true, complete and correct, and I make this declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath. I also understand that misstatements or omissions of material facts may be cause for denial of this application, or for suspension or revocation of registration.

By signing this application, I authorize the College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia (CTCMA) to collect the personal information that I have provided in this application form and to use that personal information for the purposes of processing my application for the purposes of registration under the *Health Professions Act*, RSBC 1996, c. 183 and I consent to the disclosure of that personal information to Yardstick Software Inc. for the purposes of administrating the examination, processing my examination results and providing information regarding my examination results back to the CTCMA.

I further acknowledge that this application must be submitted to CTCMA no later than August 1, 2018.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date



### DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a disability that requires an accommodation in taking the registration examination, please have this section completed by an appropriate professional (e.g., physician, psychologist, rehabilitation counselor, special educator, or other professional registered with a professional regulatory body) to certify that your disabling condition requires the requested test accommodation.

I have known \_\_\_\_\_ since \_\_\_\_\_  
(Candidate Name) (Date)

in my capacity as a \_\_\_\_\_  
(Professional Title)

Because of the nature of the candidate's disability: \_\_\_\_\_  
\_\_\_\_\_  
(description of the candidate's disability)

it is my opinion that the candidate should be accommodated by providing the following (check all that apply):

- Separate Room
- Reader
- Recorder
- Additional Time:
- Other:
- Large Print Exam
- Large Print Answer Sheet
- Kurzweil Format

Specify additional number of minutes needed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

_____ Name	_____ Professional Regulatory Body
_____ Professional Title	_____ Registration/License No.
_____ Signature	_____ Date