Health Care Professional Recommendation for Qualifying Examination Accommodation Form

Instructions:
Please complete this form in its entirety and submit it to the College of Patent Agents and Trademark Agents (CPATA) via email, along with all required supporting documentation, to the attention of the Director of Registration at registration-inscription@cpata-cabamc.ca..

All Agents in Training registered in the College's registration program are required to successfully complete the applicable qualifying examination(s) to be eligible to be licensed as a Patent and/or Trademark Agent in Canada. Please review the detailed descriptions of the format and length of the Patent Agent Qualifying Examinations and Trademark Agent Qualifying Examinations. The qualifying examinations assess whether a given agent in training demonstrates the minimum level of competence required of an entry-level patent and/or trademark agent.

Agents in Training may request accommodation for a qualifying examination based on a ground in the Canadian Human Rights Act, R.S.C., 1985, c. H-6. To request accommodation based on disability, an agent in training must complete and submit a Request for Accommodation Form and provide supporting medical documentation from a regulated health care professional licensed to diagnose and/or treat the condition/disability.

PLEASE NOTE: Agents in training must provide medical confirmation that the condition/disability is present and information to assist the College to ensure an appropriate accommodation. Agents in training may voluntarily provide more detailed information about their disability, including a specific diagnosis. The College uses the information solely to address the accommodation request and reasonably related matters. Unless there is consent, the College does not disclose the information to others.

Information for Agents in Training:
Provide this form to a regulated health care professional, licensed to diagnose the condition **and/or treat** the condition for which you are requesting accommodation. The professional must confirm the presence of a condition for which you are requesting accommodation and information regarding related anticipated functional limitations. The professional is not required to disclose the diagnosis.

The health care professional completing this form should submit it with supporting documentation directly to the College in one email message to registration-inscription@cpata-cabamc.ca. The email subject line should read: "***Health Care Professional Recommendation for Qualifying Examination Accommodation Form - Candidate Last Name, Candidate First Name.***"

Sign this form where indicated below to give your health care professional permission to provide the supporting information and any more detailed information (e.g., a diagnosis), as applicable.

It Is strongly recommended that you password protect any documents transmitted via email. Please provide the password in an email separate from your submission.

Section 1: To be Completed by the Agent in Training
Current Legal Name

First Name: _____ Middle Name: _____ Last Name: _____

CPATA #: _____

Date of birth:

I authorize the health care professional named below to share information concerning the functional impact of my condition(s) with the College of Patent Agents and Trademark Agents for the purpose of addressing my accommodation request.

Consent to disclosure of diagnosis to the College:

☐ I consent to my diagnosis being identified on this form.

☐ I do NOT consent to my diagnosis being identified on this form.

Agent in Training Signature Date

Information for Health Care Professionals:
The above-named agent in training has requested accommodation for a qualifying examination based on a condition. In order to address their request, the College requires supporting medical documentation from a regulated health care professional licensed to diagnose and/or treat the condition for which accommodation is being requested.

You must have made the diagnosis, or be able to confirm the presence, of the condition for which the agent in training is requesting accommodation.

Accommodations help to create an equitable examination by ensuring that candidates are not effectively barred from qualifying for practice because of one or more Canadian Human Rights Act grounds.

Your input will be essential in determining appropriate examination accommodations for the agent in training.

Please be sure the agent in training has signed above. You must answer the questions below, attaching appendices where additional space is necessary. Once completed, submit this form and any appendices

directly to the College by attaching them to one email message and emailing to registration-inscription@cpata-cabamc.ca. The email subject line should read: "***Health Care Professional Recommendation for Qualifying Examination Accommodation Form - Candidate Last Name, Candidate First Name.***"

Please ensure that your responses are LEGIBLE.

Section 2: To be Completed by the Health Care Professional

Name: _____

Profession: _____

Name of Regulatory Body: _____

Licence/Registration Number: _____

Office/Organization Name: _____

Street/Apt. No. _____ City _____ Province _____ Postal Code _____

Phone: _____ Email Address: _____

Section 3: Health Care Professional Qualifications

In this section, please describe your professional qualifications. Please provide information about (a) your area(s) of practice, (b) any specialties, and (c) experience determining functional limitations as they relate to accommodation needs for licensing examinations.

Areas of practice	Specialties	Experience

Section 4: Confirmation of Grounds for Accommodation

In this section, please confirm that the above-named agent in training is affected by a disability, medical condition, disorder, pregnancy-related need, or maternity-related need and describe the associated functional limitations that impact their ability to write the qualifying examination(s) under standard testing conditions as outlined on the pages linked above.

How long has the agent in training been in your care?

When was the agent in training diagnosed with the condition?

Did you diagnose the condition? ☐ Yes ☐ No

If you did not diagnose the condition, did you confirm the condition?
(leave blank if you diagnosed the condition) ☐ Yes ☐ No

How was the condition diagnosed or confirmed? (select all that apply)

One or more specific objective tests? ☐ Yes ☐ No

Please specify the tests used:

Medical observation? ☐ Yes ☐ No

Self-report? ☐ Yes ☐ No

Any other method? (Please describe)

How would you describe the impairments associated with their condition?

Chronic ☐ Temporary ☐ Intermittent ☐

Please explain:

For documentation dated more than two (2) years ago, a statement regarding the stability and/or changes to the limitations of the agent in training must be provided, to determine their impact on accommodation needs for the current assessment.

All documentation submitted to support a request must be on official letterhead and include the person's credentials and contact information.

Section 5: Areas of Impairment and Severity
Please indicate the of areas of impairment, severity of impairment and describe the functional limitations of the impairment and its impact on examinations in a standard testing environment.

If you are recommending additional writing time to complete an examination due to a neurodevelopmental or cognitive condition, please identify the issues affecting the agent in training's development, functioning, severity of condition, and current treatment in the chart below. Please describe how the agent in training is affected and how the functional limitations are caused by the impairment, to provide a measurable basis to justify the recommendation for additional writing time. All recommendations for additional writing time must indicate exactly how much additional writing time is requested.

Severity:

- Mild: The agent in training should be able to cope with minimal support.
- Moderate: The agent in training requires some degree of accommodations, as symptoms are more prominent.
- Serious: The agent in training has a high degree of impairment. Significant accommodations may be required as symptoms and impact interfere with functioning.

Area of Impairment	Severity	Functional Limitations and Impact on Examinations
Cognitive/Mental:		
• Understanding, remembering, carrying out directions		
• Concentrating		
• Processing information (e.g. understanding, analyzing, synthesizing)		
• Executive functioning (ability to multi-task, prioritize, organize and manage time)		
• Reading		
• Other (please specify)		

Physical:		
• Chronic physical illness		
• Restricted ability to sit for a sustained period of time		
• Chronic or episodic pain		
• Deaf, deafened, hard of hearing		
• Low vision, blind, eye fatigue/strain		
• Physical mobility		
• Reduced stamina/need for frequent breaks		
• Other (please specify)		

Section 6: Equipment and Assistive Devices (if applicable)

If applicable, please list the equipment or assistive devices you recommend the agent in training use during the examination and provide a brief reason for each.

Request	Reason

Section 7: Health Care Professional Confirmation and Signature

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

Health Care Practitioner Signature Date

This form and any appendices must be submitted by the health care professional who signed above directly to the College. Please attach the form with any appendices to one email message and send to registration-inscription@cpata-cabamc.ca. The email subject line should read: "***Health Care Professional Recommendation for Qualifying Examination Accommodation Form - Candidate Last Name, Candidate First Name.***" It Is strongly recommended that you password protect any documents transmitted via email. Please provide the password in an email separate from your submission.