



**College of Dietitians of British Columbia (CDBC)**  
**Form B: Candidate Application for Testing Accommodations**  
**Mental or Physical Disability Related Needs Form**

If you have a disability, a temporary disability, or a medical condition or disorder that may require an accommodation when writing the Assessment for Substantial Equivalence, please complete Section A of this form and forward it to an appropriate regulated health care professional, who, in Section B, must describe the specific accommodation you need, along with rationale for this recommendation. The health care professional is to send the completed form and any indicated supporting documentation directly to CDBC. The diagnosis may be redacted.

**SECTION A: (COMPLETED BY CANDIDATE)**

Name: \_\_\_\_\_

Assessment(s): \_\_\_\_\_

Accommodation Requested:

- Additional testing time:
  - 25% additional time (Knowledge Assessment: 3.75 hours; Practical Assessment: 3.125 hours)
  - 50% additional time (Knowledge Assessment: 4.50 hours; Practical Assessment: 3.75 hours)
  - Other: \_\_\_\_\_
  
- Reader

Note: The Assessment for Substantial Equivalence is composed of a Knowledge Assessment and a Practical Assessment. The Knowledge Assessment is a computer-based 3-hour multiple-choice exam without a break, administered by remote proctoring in a virtual format. The Practical Assessment is a 2.5-hour virtual panel interview with case-based scenarios. The Assessments aim to confirm that candidates meet the entry-level competencies to practice safely in British Columbia.

Break Time:

10-minute mid-assessment break:

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Other:

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\*Break time provided to the candidate cannot be used as additional testing time. Once an approved accommodation break has started, the candidate cannot review any previous questions.

<b>Disability/Condition</b>	<b>Appropriate Health Care Professional<sup>1</sup> to complete Section B</b>
Hearing Impaired	Audiologist
Vision Impairment	Optometrist or Ophthalmologist
Learning Disability	Psychologist, Psychiatrist, or other qualified health care professional.
Physical Disabilities	An appropriate health care professional.
Attention Deficit Hyperactivity Disorder	Psychologist, Psychiatrist, or other qualified health care professional.
Psychiatric Disorders	Health care professional must be competent to evaluate and diagnose psychiatric disabilities. Evaluation must have been made within the last 12 months.
Autism Spectrum Disorder	Health care professional competent in assessing Autism Spectrum Disorders.
Brain Injury	An appropriate health care professional.
Dietary restrictions & allergies	An appropriate health care professional.

<sup>1</sup> An appropriate health care professional is a regulated health care professional, who is qualified to diagnose the impairment, has been involved in the candidate's assessment, and has sufficient knowledge and expertise to be able to identify what accommodations is needed in relation to the disability or special condition.

**SECTION B: (COMPLETED BY THE APPROPRIATE HEALTH CARE PROFESSIONAL)**

The purpose of the Assessment for Substantial Equivalence is to assess candidate competence aligned with the Integrated Competencies for Dietetic Education and Practice (ICDEP) at the same level expected of students who have successfully completed an approved Canadian dietetics education program. As such, the Assessment for Substantial Equivalence is an important process to support the college regulatory functions and mandate of protecting the public. The Assessment for Substantial Equivalence is composed of a Knowledge Assessment and a Practical Assessment. The Knowledge Assessment is a computer-based 3-hour multiple-choice exam without a break, administered by remote proctoring in a virtual format. The Practical Assessment is a 2.5-hour virtual panel interview with case-based scenarios. The Assessments aim to confirm that candidates meet the entry-level competencies to practice safely in British Columbia. We rely on the health care professional's expertise to recommend a specific accommodation based on their understanding of the candidate's functional limitation and needs associated with the disability.

I have known this candidate since \_\_\_\_\_ in my capacity as a \_\_\_\_\_.

I confirm that I have used my own professional judgement and identified a clear link between the candidate's disability and how it is addressed in the accommodation. I understand that the purpose of an accommodation is to provide equity, not advantage.

Professional Designation/Title: \_\_\_\_\_ License Number: \_\_\_\_\_

Date of last patient visit: \_\_\_\_\_

(The reason for the accommodation must be current. For example, the accommodation will not be granted for a childhood condition that a candidate no longer suffers from.)

I verify that the candidate has a diagnosed disability or condition:

- Yes
- No

"Test anxiety" is normally not seen as a disability unless it is a limitation of a more encompassing psychiatric disorder.

- The recognized diagnosis was provided by me
  - The diagnosis was recognized by another qualified regulated health care professional
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The approximate date when the disability or condition was first diagnosed and/or identified.

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A brief history and description of the functional limitations that prevent the candidate from writing the assessment in the usual method and/or environment. Attach separate letter if needed.

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Describe how the functional limitations of disability or condition impact the person's ability to write the Assessment for Substantial Equivalence in the usual method and/or environment. This should reflect the candidate's current impairment. Requested accommodations must be tied to specific assessment results.

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Accommodation Requested:

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  - 50% additional time (Knowledge Assessment: 4.50 hours; Practical Assessment: 3.75 hours)
  - Other

- Reader

- Break Time:

- 10-minute mid-assessment break:

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- Other:

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\*Extra break time provided to the candidate cannot be used as additional testing time. Once an approved accommodation break has started, the candidate cannot review any previous questions.

A description of current treatment plan and why this is not effective in overcoming the functional limitations of the disability or condition, thereby necessitating the above accommodation(s).

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Name:

Date:

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Signature:

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Telephone:

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Email:

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