



**A P E G S**

*Association of Professional Engineers  
& Geoscientists of Saskatchewan*

**Regulating the  
professions.  
Protecting the  
public.**

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## **Application for Special Accommodations for the National Professional Practice Examination**

**Please read the information on the website before completing this form. Type or print legibly.**  
You may submit the completed form by email to [professional-practice-exam@apegs.ca](mailto:professional-practice-exam@apegs.ca)

Complete this form in consultation with your medical professional and return it to APEGGS with your application to write the National Professional Practice Exam (NPPE). All requests for special accommodations will be considered by APEGGS on a case-by-case basis.

### **THIS SECTION MUST BE COMPLETED BY THE CANDIDATE**

**Name of Candidate:**

**Registration Number:**

### **Applicant Authorization for Release of Information**

- I authorize the release of the information on this form to the Association of Professional Engineers & Geoscientists of Saskatchewan (APEGGS).
- I declare that the information provided by my medical practitioner is true and accurate.
- I understand that providing false or misleading information would be a breach of the Good Character Guideline and would therefore have consequences aligned with APEGGS regulatory responsibilities and existing standards for professional conduct.
- I understand that a breach of exam conduct standards may also be reported to other Canadian engineering/geoscience regulators in accordance with inter-provincial information-sharing protocols.

Candidate Signature:

Date:

Please note: Your medical information will not be shared with anyone outside of APEGGS unless required to do so by law.

#### **\*Notes:**

- Granted accommodations are valid for sessions held in the same calendar year only. Candidates must submit a new request for any exam sessions for subsequent years.
- Approved special accommodation requests will be conveyed to candidates 1 – 2 weeks prior to the exam date by email from Meazure Learning.

**Forms containing incomplete information will not be assessed.**

## MEDICAL ASSESSMENT

**THIS SECTION MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER**

**Name of Candidate:**

**Registration No:**

Last Name of Practitioner		First Name of Practitioner	
Address:			
Telephone		Email	
Provide details explaining why testing accommodation(s) are needed for a computer-based exam based on the disability:			
Please describe the special accommodation(s) that the candidate requires to write the exam:			
Stamp and Signature:		License Number:	Date:

Please contact the APEGS office should you have questions or concerns.