



Canadian Association of Registered Diagnostic Ultrasound Professionals
Association Canadienne des Professionnels Autorisés en Échographie Diagnostique

CARDUP ACPAED

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Exam Change Request must be received by CARDUP within 5 business days of your scheduled exam.

CARDUP Examination Change Request

1. IDENTIFICATION (PLEASE PRINT OR TYPE LEGIBLY.)

_____ Date: _____
 First Name Middle Initial Last Name (date / month / year)

_____ Street Address

_____ P.O. Box or Rural Route (if applicable) _____ City

_____ Province _____ Postal Code _____ Country

_____ CSDMS / CARDUP No. (if applicable) _____ Date of Birth (date / month / year)

() _____ () _____
 Home Telephone Number Work Telephone Number

2. FOR WHICH EXAMINATION(S) HAVE YOU RECEIVED AN AUTHORIZATION TO WRITE NOTICE:

<input type="checkbox"/> Core	<input type="checkbox"/> May	<input type="checkbox"/> BCIT	<input type="checkbox"/> Michener
<input type="checkbox"/> Generalist	<input type="checkbox"/> September	<input type="checkbox"/> NAIT	<input type="checkbox"/> Collège Boréal
<input type="checkbox"/> Cardiac	<input type="checkbox"/> January	<input type="checkbox"/> SAIT	<input type="checkbox"/> QEII / Dalhousie School of Health Sciences
<input type="checkbox"/> Vascular	Indicate Year _____	<input type="checkbox"/> Winnipeg Health Sciences	<input type="checkbox"/> College of the North Atlantic
		<input type="checkbox"/> Mohawk	

3. PLEASE INDICATE BELOW THE EXAMINATION(S) FOR WHICH YOU ARE REQUESTING A CHANGE AND INDICATE THE NEW DATE AND / OR LOCATION. * IF YOU ARE ADDING OR SWITCHING THE EXAM COMPONENT(S) THAT YOU WISH TO WRITE, PLEASE ENSURE THAT YOU PROVIDED THE NECESSARY PREREQUISITES WITH YOUR ORIGINAL EXAM APPLICATION. IF YOU DID NOT, YOU CAN NOT CHANGE COMPONENTS. INSTEAD, YOU MUST COMPLETE AN EXAMINATION WITHDRAWAL AND REFUND REQUEST AND THEN COMPLETE AND SUBMIT A NEW EXAMINATION APPLICATION WITH THE APPROPRIATE PREREQUISITES***.**

	Remove	Add			
<input type="checkbox"/> Core	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> May	<input type="checkbox"/> BCIT	<input type="checkbox"/> Michener
<input type="checkbox"/> Generalist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> September	<input type="checkbox"/> NAIT	<input type="checkbox"/> Collège Boréal
<input type="checkbox"/> Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> January	<input type="checkbox"/> SAIT	<input type="checkbox"/> QEII / Dalhousie School of Health Sciences
<input type="checkbox"/> Vascular	<input type="checkbox"/>	<input type="checkbox"/>	Indicate Year _____	<input type="checkbox"/> Winnipeg Health Sciences	<input type="checkbox"/> College of the North Atlantic
				<input type="checkbox"/> Mohawk	

FOR CARDUP OFFICE USE ONLY

Date received: _____ Date of Processing Switch: _____

Special Notes: _____