REQUEST FORM FOR TESTING ACCOMMODATIONS

Accommodation Form Submission Requirements:

1. Once **ALL** fields are completed submit the *Request Form for Testing Accommodations* to the Board.

2. When information is missing or the required documentation is not provided delays may occur. A discrepancy email/letter will be sent from the Board identifying the missing information/documents.

3. The form **MUST** be completed by a practitioner authorized to diagnose the condition that establishes the basis for the accommodation request (for example, licensed physician, psychologist, certified registered nurse practitioner, physician assistant, optometrist, or audiologist).

4. The accommodations requested must be **specific** (if extended time, for example, 2 hours, separate room, etc.) and in compliance with the federal Americans with Disabilities Act (ADA).

5. A copy of the most recent evaluation related to the diagnosis and applicable testing results **MUST** accompany the accommodation form for the request to be considered complete.

6. Additional documentation may be requested and is the responsibility of the applicant to obtain and submit.

7. On reexamination, applicants will receive the same accommodations as initially granted unless requesting a change in the accommodation originally provided. Any modifications to the original request requires submission of a new accommodation request and documentation.

SECTION 1: COMPLETED BY APPLICANT REQUESTING ACCOMMODATIONS:

Last Name: ________________________________________________________________

First Name: ______________________________________________________________

Last Four Digits of Social Security Number: ________________________________

SECTION 2: COMPLETED BY THE NURSING EDUCATION PROGRAM DIRECTOR:

Nursing Education Program Name: ___________________________________________

Were modifications provided in the nursing education program? Yes _______ No _____

Describe modifications provided: _____________________________________________

__________________________  ______________________________
Director Signature and Title: __________________________________ Date: _____________

Telephone number: _________________________________________________________

Revised: 10/2017
SECTION 3: COMPLETED BY A LICENSED HEALTH CARE PROVIDER: The form must be completed by a practitioner authorized to diagnose the condition that establishes the basis for the accommodation request (for example, licensed physician, psychologist, certified registered nurse practitioner, physician assistant, optometrist, or audiologist).

Applicant Last Name: ___________________________________________________________

Applicant First Name: _________________________________________________________

Specific diagnosis(es): _________________________________________________________

__________________________________________________________

Diagnostic Code(s) and Title(s): ________________________________________________

Treatment/medication history: __________________________________________________

__________________________________________________________

Date of initial diagnosis(es) and treatment: ________________________________________

Date of most recent testing/evaluation*: __________________________________________

*It is required that you ATTACH a copy of the testing/evaluation that supports the diagnosis(es), Refer to Instruction #5)

Current treatment/medication status: _____________________________________________

__________________________________________________________

Specific Accommodation(s) requested (Refer to Instruction #4) ______________________

__________________________________________________________

Rationale: _________________________________________________________________

__________________________________________________________

Professional’s name (type or print legibly): _______________________________________

Professional’s signature: ___________________________________ Date: ________________

State of Licensure: ___________________________ License Number: ___________________

Specialty certification/qualifications (as applicable): ________________________________