ADA EXAMINATION ACCOMMODATION REQUEST FORM

The Application for Disability Accommodations is to help The Conference determine (1) whether you are a qualified disabled individual under applicable federal, state, provincial, or local legislation and (2) whether the accommodation you are requesting is reasonable. Consideration of all requests will be made under applicable laws. This completed form must be submitted with your exam application. The Practitioner's Statement must be submitted directly from the office of the practitioner.

SUBMIT TO: The Conference, 1885 Shelby Lane, Fayetteville, AR 72704 *or* exams@theconferenceonline.org *or* via fax 479-442-7090

Name: _____

First Middle/M.I. Last

Address:_____

City, State, Zip:_____

Email: _____ Daytime Phone Number: _____

Major life activity impaired by disabling condition: _____

Examination Applied for:

- ☐ NBE
- ☐ SBE
- ☐ LRR

Physicians or Other Health Care Practitioners:

(a) Name: _____

Office Address: _____

_____

Length of time as patient: _____

Physicians or Other Health Care Practitioners:

(b) Name: _____

Office Address: _____

_____

Length of time as patient: _____

Release:

I authorize each health care practitioner listed above to release to the International Conference of Funeral Service Examining Boards (ICFSEB), or their designated representatives, information which will verify the current functional limitations imposed by my disability which affect my ability to perform under standard testing conditions; and describe the nature of the examination accommodation(s) being proposed and the rationale for those accommodation(s). I further understand that I may be asked to provide additional information about my functional limitation(s) and the requested accommodations and agree to cooperate with reasonable requests for such additional information.

I understand and agree that the information obtained by this authorization will be used solely for the purpose of determining my eligibility for reasonable accommodations in regard to the examination(s) administered by The Conference and extent of the accommodations which are reasonably necessary by reason of my disability. The information obtained by this authorization will not be released or disclosed to any person or organization except the referenced parties, and any other governmental agency that may be involved in acting upon my request for reasonable accommodations in connection with the funeral service licensure process.

I agree that this authorization shall be valid until canceled or revoked in writing by me. The documents released by the health practitioner will be treated as confidential.

Under penalties of perjury, I declare that the foregoing statements and those in any required accompanying documents or statements are true. I understand that providing false information may result in denial of access to the examination(s), invalidation of examination score(s), denial of access to future examination(s) and notice of such actions to the Conference membership.

Signature: _____ Date:_____

Please note that any approved accommodations must be scheduled through the Accommodations Coordinator at Pearson VUE.

APPLICATION FOR DISABILITY ACCOMMODATIONS—PRACTITIONER'S STATEMENT

(A copy of this form must be completed by each health care practitioner providing services to the patient.)
This form must be submitted directly from the office of the practitioner, with identifying cover page or letterhead.

SUBMIT TO: The Conference, 1885 Shelby Lane, Fayetteville, AR 72704 *or* exams@theconferenceonline.org *or* via fax 479-442-7090

Please note: The evaluation must be **current** and meet the following guidelines:
i. Learning Disabilities: <5 years old; ii. ADHD: <3 years old; iii. Psychiatric/psychological: <1 year old;
iv. Physical/chronic health conditions: Generally < 1 year old, depending on the condition and its expected duration

Practitioner Name: _____
Last First Middle/M.I.

Office Name: _____

Office Address: _____

Office Phone Number: (_____) _____

Patient's Name: _____

Patient's Address: _____

1. Diagnosis and description of disabling condition: _____

_____

_____

Date patient first seen: _____ Date patient last seen: _____

2. Date of onset: _____

3. Major life activity(ies) limited by disabling condition (e.g., walking, seeing, breathing, etc.) _____

_____

_____

4. Attach/cite the diagnostic criteria and tests administered with dates of results and interpretations. _____

_____

_____

5. Circumstances under which previous accommodations were granted and dates of occurrences: _____

_____

6. Accommodation(s) needed for a **licensing exam**: _____

_____

_____

I hereby certify that the above information is true and is released pursuant to authorization by my patient.

Signature of Health Care Practitioner: _____ Date: _____

Professional Status (physician, psychologist, etc.): _____

FOR CONFERENCE USE:

Conference Approval:_____ Date:_____