

INSTRUCTIONS:

Exam candidates seeking ADA testing accommodations should complete this form in its entirety and submit it directly to The Conference. Refer to the ADA Testing Accommodations Handbook for all further instructions.

EXAM CANDIDATE INFORMATION:

Candidate Name: _____
First Middle Last

Email: _____ Phone Number: _____

Examination(s) Applying For: NBE LRR

Briefly describe the disability:

List the major life activities limited by the disabling condition (e.g., walking, hearing, speaking, seeing, reading, or writing): _____

Please state what accommodations you are seeking for your exam:

HEALTH PRACTITIONER INFORMATION:

List each health practitioner (e.g., physician, therapist, etc.) that is treating you for the disability(ies) described above. Attach additional sheets if necessary. Each treating practitioner must submit a Health Practitioner Statement directly to The Conference.

Name: _____ Professional Title: _____

Office Address: _____

Phone Number: _____ Length of Time as Patient: _____

Name: _____ Professional Title: _____

Office Address: _____

Phone Number: _____ Length of Time as Patient: _____

TESTING ACCOMMODATIONS HISTORY:

If you have previously been provided with testing accommodation(s), please list the time frame and a description of the accommodations. If no testing accommodations were provided to you in the past, provide a written explanation why accommodations are requested now and why they were not requested/provided in the past.

Authorization & Release:

I authorize each health practitioner listed to release to the International Conference of Funeral Service Examining Boards (The Conference), 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; describe the nature of the examination accommodation(s) being requested 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. 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.

The documents released by the health practitioner will be treated as confidential. I acknowledge and agree that documents for Conference administered exams must be current under the following guidelines stated in the ADA Testing Accommodations Handbook.

Under penalties of perjury, I declare the submitted statements and any additional documents 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, including the jurisdiction in which I am seeking licensure. I hereby attest that I personally completed this request form and agree to verify information if requested.

Printed Name: _____

Signature: _____ Date: _____

Submit the fully completed form via email, fax, or postal mail. Incomplete submissions will not be reviewed.

Email: annascott@theconferenceonline.org

Fax: 479-442-7090

Mail:

The Conference
ATTN: Testing Accommodations
1885 Shelby Lane
Fayetteville, AR 72704