INSTRUCTIONS - *ADA Testing Accommodations Request for Licensing Exam*

The treating practitioner must complete this form and submit it, along with all supporting documentation, directly to The Conference with identifying letterhead, coversheet, or equivalent. This form will not be accepted if submitted by the candidate.

An evaluation of the stated disability must have been conducted within the last 3 years.

HEALTH PRACTITIONER INFORMATION:

Health Practitioner Name: _____

Professional Title: _____

Office Name & Address: _____

Office Phone: _____ State License Number: _____

Professional training, credentials, licensing and specialization to support relevant diagnoses and appropriate recommendation (or attach current CV):

_____

_____

PATIENT/EXAM CANDIDATE INFORMATION:

Patient Name: _____

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

Number of Years as a Patient: _____ Patient Phone: _____

Diagnosis and description of disability:

_____

_____

_____ Date of onset: _____

Major life activities limited by disabling condition (e.g., walking, seeing, reading, etc.):

_____

_____

_____

Attach/cite the diagnostic criteria & tests administered with dates of results & interpretations:

_____

_____

_____

_____

Circumstances under which previous accommodations were granted and dates of occurrences. If no accommodations were provided in the past, provide an explanation why accommodations are requested now and why they were not previously requested:

_____

_____

_____

_____

Accommodation(s) recommended ***specifically for a licensing exam***:

_____

_____

_____

REQUIRED ATTACHMENTS:

I. A written statement explaining the diagnosis and its impact on the candidate's abilities relative to the request for special accommodations on a licensing exam.

II. A written explanation for each recommended accommodation, including the current treatment for the disability (e.g., any medication management or physical aids). Any current and applicable test(s) used to support the diagnosis or recommendation for accommodations should be submitted. More detailed information can be found within the ADA Testing Accommodations Handbook located at http://theconferenceonline.org/ada/.

Certification: I hereby certify that the information that I provide pursuant to this Health Practitioner Statement is true and correct and is provided pursuant to the authorization to release information signed by my patient. I further certify that I have the necessary specialized training to make the diagnosis herein, that I personally examined the candidate named herein, and that I used my professional judgment to render the diagnosis herein and assess the accommodation request specifically for a licensure exam.

Signature: _____ Date: _____

Submit fully completed form with identifying letterhead, coversheet, or equivalent via email, fax, or postal mail directly to The Conference from the Health Practitioner. 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