

PERSONS WITH DISABILITIES ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission.

Name _____
last first middle

Address _____
number street apt. no.
_____ city state ZIP/Postal code

Phone numbers (____) _____ (____) _____
home business

Social Security Number _____

Accommodations requested for the _____ examination.

Please check all that apply:

- Accessible Testing Site
- Braille Large print Tape
- Reader as accommodation for visual impairment
- Scribe/amanuensis as accommodation for visual or motor impairment
- Reader as accomodation for learning disability
- Scribe/amanuensis as accommodation for learning disability
- Sign Language Interpreter
- Extended Time
 - Time-and-a-half Double time More than double time (specify): _____

- Separate testing area
- Use of computer or other adaptive equipment (specify): _____
- Other _____

Comments _____

Signature _____ Date _____

Some accommodation requests may require additional documentation (see next page).

Return this form, along with your application for certification to:

Board of Pharmaceutical Specialties
2215 Constitution Ave., NW
Washington, DC 20037-2985

DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

IF YOU HAVE EXISTING DOCUMENTATION OF HAVING THE SAME OR SIMILAR ACCOMMODATION PROVIDED TO YOU IN ANOTHER TEST SITUATION, YOU MAY SUBMIT SUCH DOCUMENTATION INSTEAD OF HAVING THIS PORTION OF THE FORM COMPLETED.

I have known _____ since _____ in my capacity
(test applicant) (date)

as a _____ .
(professional title)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following:
(check all that apply)

- Taped test
- Large print test
- Reader
- Scribe/amanuensis
- Extended Time
 - Time-and-a-half*
 - Double time*
 - More than double time (specify):*

Separate testing area _____

Use of computer or other adaptive equipment (specify): _____

Other _____

Signature _____

Date _____

Title _____ License # (if applicable) _____

Return this form, along with your application for certification to:

Board of Pharmaceutical Specialties
2215 Constitution Ave., NW
Washington, DC 20037-2985
