NBRC
The National Board for Respiratory Care®

Request for Special Examination Accommodations

If you have a disability covered by the Americans with Disabilities Act, complete this form and the Documentation of Disability-Related Needs on the reverse side and submit it for approval **PRIOR to applying and making payment**. If the form is not received prior to making payment and scheduling a testing appointment, approved accommodations will not be provided for your scheduled examination. Please **allow 5-7 business days** for processing. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality.

Applicant Information

Social Security # _____ – _____ – _____

_____

Last Name | First Name | Middle Name

_____

Address

_____

City | State | Zip Code

_____

Daytime Telephone Number | Email Address

Special Accommodations

I request special accommodations for the examination below.

- ☐ Therapist Multiple-Choice (TMC) - Ends December 31, 2026
- ☐ Clinical Simulation (CSE) - Ends December 31, 2027
- ☐ Respiratory Therapy (RT) - Effective January 1, 2027
- ☐ Pulmonary Function Technology (PFT)
- ☐ Neonatal/Pediatric Specialty (NPS)
- ☐ Sleep Disorders Specialty (SDS)
- ☐ Adult Critical Care Specialty (ACCS)
- ☐ Asthma Educator Specialty (AE-C)

Please provide (check all that apply):

- _____ Reader
- _____ Extended testing time (time and a half)
- _____ Reduced distraction environment
- _____ Other special accommodations (please specify)

_____

_____

_____

Comments: _____

_____

_____

Signed:_____ **Date:** _____

Mail completed form to NBRC, 10801 Mastin Street, Suite 300, Overland Park, KS 66210-1658, or email to apply@nbrc.org. If you have questions, call the NBRC at 913.895.4900.

Documentation of Disability-Related Needs

If you have a learning disability, a psychological disability, or other disability that requires an accommodation in testing, please have this section completed by an appropriate professional (doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested examination accommodation. **If you have existing documentation of the same or similar accommodation provided for you in another examination situation, you may submit such documentation in addition to completing the "Professional Documentation" portion of this form.**

Professional Documentation

I have known _____ since _____ / _____ / _____ in my capacity as a
Candidate Name Date

_____.
My Professional Title

The candidate discussed with me the nature of the test to be administered. It is my opinion that, because of this candidate's disability described below, he/she should be accommodated by providing the special arrangements listed on the reverse side.

Description of Disability:_____

_____

_____

_____

_____

Signed:_____ Title: _____

Printed Name:_____

Address:_____

_____

Telephone Number:_____ Email Address: _____

Date:_____ License # (if applicable): _____

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