Request for Special Examination Accommodations

If you have a disability covered by the Americans with Disabilities Act, please complete this form and the Documentation of Disability-Related Needs on the reverse side and submit it with your application at least 45 days prior to your requested examination date. 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)
☐ Clinical Simulation (CSE)
☐ Pulmonary Function Technologist (PFT)
☐ Neonatal/Pediatric Specialty (NPS)
☐ Sleep Disorders Specialty (SDS)
☐ Adult Critical Care Specialty (ACCS)

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: _______________________________________

Return this form to: NBRC, 10801 Mastin Street, Suite 300, Overland Park, KS 66210-1658.
If you have questions, call the NBRC at 913.895.4900.
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): ______________________________________