

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. Candidates approved for accommodations are required to schedule their examination at an assessment center. 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)
- Asthma Educator Specialty (AE-C)

Please provide (check all that apply):

- _____ Reader
- _____ Screen Reader Software (i.e. JAWS)
- _____ Extended testing time (time and a half)
- _____ Reduced distraction environment
- _____ Other special accommodations (please specify)

Comments: _____

Signed: _____ **Date:** _____

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): _____

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.