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: __________________________

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.
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.