Request for Accommodations under the Americans with Disabilities Act (ADA)

1. First Name: ___________________________ MI: ______ Last Name: ____________________________

2. Address: ____________________________________________________________________________

   City: ____________________________ State: ______ Zip Code: _______________________

3. Email address: _______________________________________________________________________

4. Telephone Number: ___________________________________________________________________

5. For which of the following exams are you requesting accommodations?

   ___ HCS-D ICD-10 ___ HCS-O
   ___ HCS-H ___ HCS-C

6. Are you currently certified with a BMSC credential? ___ Yes ___ No


   Other, please specify______________________________________________________________

8. How long ago was your disability diagnosed?

   _____ Less than 1 year _____ 1–2 years _____ 2–5 years _____ Over 5 years

9. In order to fully document your need for accommodations, please include a brief personal statement
   describing your disability and its impact on your daily life and educational functioning.

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10. Have you previously received accommodations in any educational or testing situation? __ Yes  __ No

If yes, please describe the accommodations received.

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_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

11. Which of the following accommodations are you requesting?

_____ Separate testing room  _____ Extended testing time

_____ Reader  _____ Screen magnifier/zoom technology

_____ Other, please specify______________________________________________________________

I certify that the information provided above is true and accurate.

Signature: __________________________________________ Date: ____________________________

Print Name: ________________________________________
Form B—Documentation of Disability-Related Needs

To the Professional:

By submitting this form with your signature and license number, you are attesting that you have formally diagnosed the candidate named on this form as having the disability documented below or, in a professional capacity, have worked with the candidate in dealing with the documented disability. You further verify that the accommodation you recommend is necessary to fairly demonstrate the candidate’s ability on the examination.

The intent is to provide equal opportunity for all candidates. The accommodation must not unfairly advantage or disadvantage the candidate.

I have known _____________________________________________________________ since (date)____________________________ in my capacity as a ________________________________________.

Please include the following:

- Diagnosis codes from the ICD-10 Classification system (note: mental and emotional disabilities must include a diagnosis code from the DSM-IV)
- Description of the candidate’s disability and how the disability affects the candidate’s major life activities (for example: hearing, seeing, walking, talking, performing manual tasks, etc).
- Recommended accommodations

_____________________________________________________________________________________
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_____________________________________________________________________________________

Signature: ___________________________________  ________________________

Print Name: ___________________________________________________ Date: _________________

Print Title: ____________________________________________________________

License number: ________________________________