NAHP Special Accommodations Request Form

If you have a disability covered by the Americans with Disabilities Act (ADA), please complete this form, have the Documentation of Disability-Related Needs Form filled out by a qualified health care professional and submit along with the Certification Application. The information you provide, and any documentation regarding your disability and special accommodation, will be treated with strict confidentiality and will not be without your express written permission, except for NAHP.

Please submit forms to: National Association for Health Professionals
PO Box 459
Gardner, Kansas 66030

APPLICANT CONTACT INFORMATION		
First Name:	Last Name:	
Middle Initial:	Social Security #:	
Personal Address:		
City:	State/Province:	ZIP Code:
Test Site Name & City	Requested Test Date:	
Email Address:		

SPECIAL ACCOMMODATIONS	
Please provide (check all that apply):	☐ Separate testing room
☐ Accessible testing center	☐ Screen Magnifier (Large Font)
☐ Extended testing time	☐ Reader Required for Visual Disability
☐ Reader Required for Learning Disability	
Other:	
Comments:	

Signature: ____ Date: _______/________/______________________

NAHP Documentation of Disability-Related Needs Form

Candidates for NAHP certification examinations who have a learning, psychological, or other disability that require accommodation during testing must provide this form along with a disability report prepared by an appropriately qualified, licensed health care professional (e.g. physician, nurse practitioner, psychologist, psychiatrist).The information you provide, and any documentation regarding your disability and special accommodation request, will be treated with strict confidentiality.

LICENSED HEALTHCARE PROVIDER DOCUMENTATION

I have known ____ since ______ /______ /_____________

Test applicant

in my capacity as a ____

Professional Title

SPECIAL ACCOMMODATIONS

The applicant has discussed with me the nature of the test administered. It is my professional opinion, that because of this applicant's disability, ______________________________ should be accommodated by providing the following:

Please provide (check all that apply):

☐ Accessible testing center	☐ Separate testing room
☐ Extended testing time	☐ Screen Magnifier (Large Font)
☐ Reader Required for Learning Disability	☐ Reader Required for Visual Disability

Other:

Comments:

Signature: ____ Date: ______________________________

Title: ____ License #______________________________________

(if applicable)