REQUEST FOR EXAM ACCOMMODATION FORM

Applicant: Complete this form only after you have read the Test Accommodation Policy on page 6 and only if you have a documented disability.

In compliance with the Americans with Disabilities Act (ADA), ABNN provides reasonable accommodations for applicants with documented disabilities that may affect their ability to take the Stroke Certified Registered Nurse (SCRN) examination. It is the candidate's responsibility to notify ABNN of the needed alternative arrangements at the time of application to sit for examination. If you have a disability for which you wish to request accommodation, you must please provide the following information and return this form with the required documentation along with your exam application. Attach additional pages as necessary.

All information provided will be held in confidence, and will only be shared with ABNN, testing service staff, and professional medical reviewers as necessary. The application includes a release for ABNN staff to contact the diagnosing physician to clarify the need for requested accommodation.

Name_____
(Last) (First) (Middle Initial)

Address_____

City _____ State _____ Zip Code _____

Day Phone_____ Evening Phone_____

Preferred e-mail_____

1. Describe your disability and how it substantially limits one or more of your major life activities:
_____

_____

_____

2. Explain the nature and extent of your disability and how it impairs your ability to take the examination:
_____

_____

3. Describe the accommodation(s) you are requesting:
_____

_____

4. Describe accommodations you have received in the past in academic and/or testing settings, including dates, type of test taken (provide documentation):
_____

_____

_____

Required Documentation for Accommodation Requests

You are required to submit documentation from the healthcare provider or learning specialist who rendered a diagnosis. Verification must be submitted to ABNN on the letterhead stationery of the healthcare provider or leaning specialist, and must include the following:

a. Specific description of the disability and limitations related to testing
b. Specific recommended accommodation
c. Name, title and telephone number of the health care provider or learning specialist
d. Original signature of health care provider or learning specialist.

ABNN may not provide the accommodation requested, but may determine a reasonable alternative accommodation.

ABNN will pay for accommodations which it approves. However, ABNN will not pay for any costs you may incur in obtaining the required documentation.

In order to make the necessary arrangements to accommodate your needs, all requests and supporting documentation must be sent to ABNN with your exam application. ABNN must approve all accommodations prior to issuing an admittance letter to the exam.

ABNN will consider all requests on a case-by-case basis. It will be necessary for testing staff to speak and correspond with you regarding specific arrangements. Therefore, it is **required** that you provide a current address and daytime telephone number and keep the staff informed if either of these changes. You will receive written confirmation of your approved accommodation(s). You **must** notify ABNN if you are unable to take the examination on the date for which you are scheduled.

My signature below grants permission for ABNN staff to contact my health care provider or learning specialist if there are questions about the documentation I have provided.

_____ _____

Applicant signature Date