



**PEDIATRIC NURSING
CERTIFICATION BOARD**

Promoting Excellence for Pediatric Nurse Practitioners and Nurses

DOCUMENTATION OF DISABILITY-RELATED NEEDS

Please have this form completed by an appropriate licensed professional (doctor, psychologist, psychiatrist or nurse practitioner) to ensure that PNCB is able to provide the required test accommodations. (Evaluations must have been performed in the last 12 months.) This form supersedes previously submitted Requests for Special Accommodations Forms.

Professional Documentation

I have known _____
since _____
in my capacity as a _____
Professional Title

The applicant discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability described below, he/she should be accommodated by providing additional time as indicated: (Please check).

- 30 minutes
- time and a half
- medical device (name device and describe in comment section)

Comments: _____

Signed: _____

Title: _____

Printed name: _____

License#: _____

Address: _____

Telephone Number: _____

Date: _____

Include this form, and your request for special exam accommodations form, along with your application and mail to PNCB, 800 S. Frederick Avenue, Suite 204, Gaithersburg, MD 20877-4151.