



PEDIATRIC NURSING CERTIFICATION BOARD

Promoting Excellence for Pediatric Nurse Practitioners and Nurses

Request for Special Examination Accommodations

If you have a disability covered by the Americans with Disabilities Act, please complete and submit this form to PN CB and ask a health care professional to complete and submit the Documentation of Disability-Related Needs Form. The health care professional must have diagnosed your disability or worked with you in dealing with the documented disability. The professional must not have familial, intimate, supervisory, or other close relationship with you and must hold a current, active license in his or her specialty. Under the ADA a disability is "a physical or mental impairment that substantially limits one or more major life activities". English as a second language, computer anxiety, or test anxiety are not covered disabilities under the ADA. Pregnancy is not covered under the ADA but if the candidate has a resulting medical complication, accommodations may be considered.

Your accommodations for testing will be evaluated. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality. This form is valid for 12 months and replaces any previously submitted forms.

Applicant Information

Last Name First Name Middle Name (Initial)

Last four digits of SSN or RN License City/State

Address:

Day time Phone Number: Evening Phone Number:

Email Address:

Diagnosis Date of Diagnosis

Special Accommodations Request

Table with 2 columns: Additional Testing Time, and rows for Thirty Minutes, 50% (time and one-half), 100% (double time), and Other, please explain.

I give my permission for my health care professional to discuss with PN CB staff my history and records as related to the requested accommodations. I understand and agree that PN CB may provide my records to an appropriate professional for an independent evaluation relating to my request. I declare that the above information is correct to the best of my knowledge and understand that false information may be a cause for denial or revocation of certification.

I confirm that I have a disability covered by the American with Disabilities Act.

Candidate Signature: Date:



**PEDIATRIC NURSING
CERTIFICATION BOARD**

Promoting Excellence for Pediatric Nurse Practitioners and Nurses

**DOCUMENTATION OF DISABILITY-RELATED NEEDS
Professional Evaluation Form**

Exam Candidate Name: _____ **Last 4 digits of SSN:** _____

Dear Licensed Health Professional,

The above-named certification exam candidate is requesting special accommodations to take a Pediatric Nursing Certification Board's (PNCB) certification exam. The exam candidate has identified you as a health care professional who holds current active licensure in your specialty and in your professional capacity has diagnosed the candidate as having the disability documented below or in a professional capacity has worked with the candidate in dealing with the documented disability within the previous 12 months. The candidate also confirms that you have no familial, intimate, supervisory, or other close relationship.

PNCB and its computer-based testing vendor comply with the American with Disabilities Act (ADA) and strive to ensure that no individual with a disability is deprived of the opportunity to take an examination solely by reason of that disability. PNCB makes special testing arrangements for any candidate with a professionally diagnosed and documented disability. Under the ADA, a disability is "a physical or mental impairment that substantially limits one or more major life activities".

I have known _____ (exam candidate's name) since
_____ (date) in my capacity as a _____.

The last time I saw this patient was: _____

The candidate has been formally diagnosed with the following disability. (Please be as specific as possible.) **Diagnosis:** Mental and emotional disabilities must include the diagnosis code from the DSM-IV or DSM-V. English as a second language, computer anxiety or test anxiety are not covered disabilities under the ADA. Pregnancy is not covered under the ADA but if the candidate has a resulting medical complication, accommodations may be considered.

Exam Candidate Name: _____ **Last 4 digits of SSN:** _____

The candidate discussed with me the nature of the test to be administered. It is my opinion that because of this exam candidate's previously described disability s/he should be accommodated by providing the following accommodation(s). Hint: If requesting additional testing time be specific (30 minutes, time and 1/2 or double time or other).

Licensed Health Professional Information

Signature_____

Print Name_____

Occupation_____

Professional Address_____

Phone Number:_____ Email Address:_____

Current Active License Number:_____ License State_____

Remit this Form to:
PNCB
2101 Gaither Road, Suite 150
Rockville, MD 20850
OR
Fax to 301-330-1504
OR
Email to exam@pncb.org