Request for Special Examination Accommodations

If you have a disability covered by the Americans with Disabilities Act, please complete and submit this form to PNCB 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

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name (Initial)</th>
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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>
<thead>
<tr>
<th>Additional Testing Time</th>
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<tr>
<td>__________ Thirty Minutes</td>
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<tr>
<td>__________ 50% (time and one-half)</td>
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<tr>
<td>__________ 100% (double time)</td>
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<td>__________ Other, please explain</td>
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I give my permission for my health care professional to discuss with PNCB staff my history and records as related to the requested accommodations. I understand and agree that PNCB 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: __________________
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

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Updated 2/6/2023