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 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 to 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

_____
Last 4 Digits of Social Security Number

Address:_____

_____

_____

Day time Phone Number:_____ Evening Phone Number:_____

Email Address:_____

Special Accommodations Request

Disability:_____

Additional Testing Time
_____Thirty Minutes
_____50% (time and one-half)
_____100% (double time)
_____Other, please explain_____

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.

Candidate Signature:_____

Date:_____

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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 ½ 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
9605 Medical Center Drive Suite 250
Rockville, MD 20850

OR

Fax to 301-330-1504

OR

Email to exam@pncb.org

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