

Appendix E – Application for Disability Accommodation

Application for Disability Accommodation Pharmacy Licensing Examinations

Instructions

The Application for Disability Accommodation is provided to assist the board of pharmacy in evaluating whether or not a qualified disability exists under applicable state or federal law, and whether or not accommodations through nonstandard testing conditions are necessary and reasonable. The form also assists the applicant in documenting a disability through verifications made by the applicant and the appropriate practitioner.

Both parts of the form must be completed as directed (using additional information if necessary) and submitted to the board of pharmacy by the established deadline. A single form applies to all pharmacy licensing examinations administered by the board. The board will be unable to process any application for a disability accommodation that is not received by the stated deadline date. While applicants are not required to provide their social security number, this information is helpful in relating this Application for Disability Accommodation to the applicant's other application materials. Applicants should retain a copy of the form for their records.

Decisions regarding reasonable accommodations and eligibility for accommodations will be made by the board of pharmacy in accordance with the provisions of state and federal law, including the Americans with Disabilities Act (ADA). Applicants will be notified, in writing, regarding what accommodation(s), if any, will be provided.

A completed Application for Disability Accommodation shall remain valid for a period of one (1) year from the date when first executed by the applicant. The form will be considered for any examination occurring within the one-year period. Applicants must resubmit documents if their disability status or requested accommodation(s) changes.

Questions or comments should be directed to the board of pharmacy in the state in which the applicant has applied to take the examination.

**Application for Disability Accommodation
Pharmacy Licensing Examinations**

PART I: APPLICANT'S STATEMENT

Name: _____

Address: _____

Social Security Number: _____

Telephone Number: _____

Birth date: _____

Examination: NAPLEX _____ MPJE _____

Description of disability and how it impacts taking examinations: _____

Physician, Therapist, or Other Health Care Practitioner: (List additional practitioners on a separate sheet of paper and attach to this form.)

Name: _____

Office Address: _____

Telephone Number: _____

Length of Time as Patient: _____

Type of Accommodation(s) Requested: _____

If you have previously been provided with test accommodation(s), please list the provider and describe the accommodation(s): _____

RELEASE

I authorize the practitioner(s) listed above to release to the Board of Pharmacy or its legal representative any and all information in his or her possession about my disability described above. "Information" means all information in the possession of, or derived from, providers of health care regarding my medical history, mental or physical condition, or treatment. I agree that this authorization shall be valid until canceled in writing by me. I understand that the Board of Pharmacy will use the information obtained by this authorization to determine eligibility for a reasonable accommodation with regard to the pharmacist licensure examination by reason of my disability. The Board reserves the right to require additional information or documentation to support this request for accommodation. The Board will not release any information obtained to any person or organization, except to NABP (the test developer), or any government agency that may be involved with my application to take the pharmacist licensure examination. Under penalties of perjury, I declare that the foregoing statements and those in any accompanying documents or statement are true. I understand that false information may be cause for denial or loss of a license. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time.

Signature: _____ Date: _____

Subscribed and sworn to before me this _____ day _____ 20 _____

Notary Public: _____

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PART II: PRACTITIONER'S STATEMENT

Practitioner Name: _____

Professional Title: _____

Office Address: _____

Telephone Number: _____

State License Number: _____
(if applicable)

Patient's Name: _____

Patient's Address : _____

Patient's Social
Security Number: _____

Date Patient
First Consulted: _____

Date Patient Last Seen: _____

Diagnosis of Disability and Basis for Diagnosis: _____

Recommended Accommodation(s): _____

CERTIFICATION

I hereby certify that the above information is true and is provided pursuant to the authorization to release information by my patient. I also certify that I have the necessary specialized training to make the above diagnosis, that I personally examined the individual named above, and that the above diagnosis and assessment of the accommodation request is my professional judgment. I understand that the Board of Pharmacy may contact me (with the applicant's permission) to obtain further information if necessary, and that the Board may obtain an independent assessment by another professional.

Practitioner's Signature: _____ Date: _____