PENNSYLVANIA STATE BOARD OF NURSING
P.O. BOX 8411
HARRISBURG, PA 17105-8411
www.dos.pa.gov/nurse

PHONE: 833-367-2762
FAX: (717) 783-0822
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REQUEST FORM FOR TESTING ACCOMMODATIONS

Accommodation Form Submission Requirements:

1. Once **ALL** fields are completed submit the ***Request Form for Testing Accommodations*** to the Board.
2. When information is missing or the required documentation is not provided delays may occur. A discrepancy email/letter will be sent from the Board identifying the missing information/documents.
3. The form **MUST** be completed by a practitioner authorized to diagnose the condition that establishes the basis for the accommodation request (for example, licensed physician, psychologist, certified registered nurse practitioner, physician assistant, optometrist, or audiologist).
4. The accommodations requested must be **specific** (if extended time, for example, 2 hours, separate room, etc.) and in compliance with the federal Americans with Disabilities Act (ADA).
5. A copy of the most recent evaluation related to the diagnosis and applicable testing results **MUST** accompany the accommodation form for the request to be considered complete.
6. Additional documentation may be requested and is the responsibility of the applicant to obtain and submit.
7. On reexamination, applicants will receive the same accommodations as initially granted unless requesting a change in the accommodation originally provided. Any modifications to the original request requires submission of a new accommodation request and documentation.

SECTION 1: COMPLETED BY APPLICANT REQUESTING ACCOMMODATIONS:

Last Name: _____

First Name: _____

Last Four Digits of Social Security Number: _____

SECTION 2: COMPLETED BY THE NURSING EDUCATION PROGRAM DIRECTOR:

Nursing Education Program Name: _____

Were modifications provided in the nursing education program? Yes_____No_____

Describe modifications provided: _____

_____

Director Signature and Title:_____Date: _____

Telephone number: _____

SECTION 3: COMPLETED BY A LICENSED HEALTH CARE PROVIDER: The form **must be** completed by a practitioner authorized to diagnose the condition that establishes the basis for the accommodation request (for example, licensed physician, psychologist, certified registered nurse practitioner, physician assistant, optometrist, or audiologist).

Applicant Last Name: _____

Applicant First Name: _____

Specific diagnosis(es): _____

_____

Diagnostic Code(s) and Title(s): _____

Treatment/medication history: _____

_____

Date of initial diagnosis(es) and treatment: _____

Date of most recent testing/evaluation*****: _____

***It is required that you ATTACH a copy of the testing/evaluation that supports the diagnosis(es), Refer to Instruction #5)**

Current treatment/medication status: _____

_____

Specific Accommodation(s) requested (**Refer to Instruction #4)** _____

_____

Rationale: _____

_____

Professional's name (type or print legibly): _____

Professional's signature: _____ Date: _____

State of Licensure: _____ License Number: _____

Specialty certification/qualifications (as applicable): _____