Application for Disability Accommodation

Pharmacist Licensing Examinations

Instructions

The Application for Disability Accommodation is provided to assist the board of pharmacy and the National Association of Boards of Pharmacy® (NABP®) NABP 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(s).

All three parts of the form must be completed as directed, attaching additional documentation as required, and submitted to the board of pharmacy. The form applies to all pharmacist licensing examinations administered by the board. Please submit the application by the determined 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.

All requests for testing accommodations will be evaluated by the appropriate board of pharmacy. Requests will be forwarded to NABP for review. The board of pharmacy and candidate may be contacted if more information is required to support the testing accommodation request.

NABP and the boards of pharmacy may share information that a candidate provides including but not limited to the request, history, and nature of the accommodations. Testing accommodation requests for candidates with disabilities will be reviewed and subsequently determined and authorized by NABP. Upon approval, NABP will notify the candidate and board of pharmacy and will arrange the appropriate exam accommodation with the testing vendor.

A completed Application for Disability Accommodation shall remain valid for a period of one 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.

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PART I: APPLICANT'S STATEMENT

Name: _____

Address: _____

_____

Social Security Number: _____ Telephone Number:_____

Birth date: _____ Examination: NAPLEX ☐ MPJE ☐

Briefly describe the disability: _____

_____

Please attach a detailed written report describing your disability and justification for the requested accommodations and current treatment prescribed for the disability (eg, mediation regiment, physical aids).

List each practitioner (eg, physician, therapist, etc). Attach additional sheets if necessary.
(Each practitioner must complete Part II: Practitioner's Statement)

Name: _____

Office Address: _____

Telephone Number: _____ Length of Time as Patient: _____

If you have previously been provided with test accommodation(s), please list the provider, the time frame, and description of accommodations.

_____

_____

_____

_____

Release

I authorize each health care practitioner listed to release to the Board of Pharmacy/NABP 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/NABP 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

(Each practitioner must complete Part II: Practitioner's Statement)

Practitioner Name: _____

Professional Title: _____

Professional Training, Credentials, Licensing, and Specialization to Support Relative Diagnoses and Appropriate Recommendation (attach proper written documentation sighting credentials):

_____

_____

_____

Office Address: _____

Telephone Number: _____ State License Number: _____

Patient's Name: _____

Patient's Address: _____

Date Patient First Consulted: _____ Date Patient Last Consultation _____

Number of Years as a Patient _____

Diagnosis of Disability and Basis for Diagnosis: _____

_____

_____

I. Please attach a supporting written statement explaining diagnosis of the disability describing the candidate's functional limitation of physical or cognitive abilities relative to justification for special accommodations. *(Evaluation must have been conducted within the past three to five years. Please provide explanation of any gaps in medical evaluations taking place prior to request for accommodations.)*

II. Please attach a written statement for each recommended accommodation(s) describing the reasoning of how it will reduce the impact of the candidate's limitation(s) and how it impacts the testing environment. It should include the current treatment for the disability (eg, any medication management or physical aids). Any current and applicable test used to support diagnosis and recommendation for accommodations should be submitted.

III. If no accommodations were provided to the candidate in the past, please provide a written explanation of why accommodations are requested now and why they were not requested in the past.

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 applicant 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: _____

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PART III: ACADEMIC/COLLEGE STATEMENT

The student named below is an applicant for the pharmacist licensing examinations and is requesting accommodations for testing for the NAPLEX/MPJE. Please complete this form and return it to the candidate.

_____ _____

Student/Applicant Name (please print) Student/Applicant Signature

College Statement

College Name: _____

Name of Person Completing Form: _____ Title: _____

Address: _____ Phone Number: _____

Please describe the accommodations(s) and reasons why it was given to this student at your institution.

_____

_____

_____

_____

Month/Year Accommodations Started and Ended: _____

The accommodation was __⊙___ a one-time event OR __○___an ongoing accommodation. (select one)

Please attach any testing results used to determine accommodations provided.
Please list the information/documentation that was the basis for this approved accommodation:

_____

_____

_____

_____

Certification

I hereby certify that the above information is true and is provided pursuant to the authorization to release information by student/applicant named above. I understand that the Board may contact me (with the student's permission) to obtain further information if necessary.

School Official's Signature: _____ Date: _____