

## ACCOMMODATION REQUEST FOR CANDIDATES WITH DISABILITIES OR IMPAIRMENTS

If you have a physical or mental impairment or limitation described under the Americans Disabilities Act (ADA), you may request special testing arrangements. To request an examination accommodation of a disability, **please submit this form with your application packet. AHNCC must receive your completed Accommodation Request form and the Provider Declaration (and related required evaluation of your disability and the appropriate accommodation) completed by a physician or other health care provider or relevant authority.** This document should state: (a) the diagnosis and nature of the disability; (b) the last time the provider saw you; (c) the name of tests used; (d) the length of the condition and (5) what accommodations(s) is suggested to accommodate the disability (impairment).

*Please provide the following information:*

Name

\_\_\_\_\_ (Last)

\_\_\_\_\_ (First)

\_\_\_\_\_ (Middle)

\_\_\_\_\_ (Maiden)

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Telephone (Home) \_\_\_\_\_

(Work) \_\_\_\_\_

Email \_\_\_\_\_

FAX \_\_\_\_\_

Anticipated Date of AHNCC Quantitative Examination \_\_\_\_\_

Description of Disability \_\_\_\_\_

Requested Accommodation \_\_\_\_\_

I understand that AHNCC will use the information obtained by this authorization to determine eligibility for a reasonable accommodation in regard to this examination by reason of my disability.

Under penalty of perjury, I declare that the foregoing statements and those in any required accompanying documents or statements are true. I understand that false information may be cause for denial or revocation of certification. I hereby certify that I personally completed this portion of this application and that I may be asked to verify the above information at any time.

Signature \_\_\_\_\_

Date \_\_\_\_\_

*Please note that the attached Provider Declaration and Instructions Form must be authorized by you (top of the page) and then completed by a physician or a licensed health care provider appropriate to the disability.*

Office use only: Date Received \_\_\_\_\_

### PROVIDER DECLARATION AND INSTRUCTIONS

**AHNCC Candidate for Certification Authorization:**

I, \_\_\_\_\_ (printed name of candidate), hereby authorize and request the provider identified below to release the information requested by AHNCC relating to my disability and the accommodation appropriate to my disability to sit for the AHNCC examination.

Signature \_\_\_\_\_ Date \_\_\_\_\_

The individual identified above is requesting accommodation to sit for the American Holistic Nurses' Certification Corporation (AHNCC) examination. AHNCC's accommodation policy requires candidates requesting accommodation to submit current documentation of the disability from an individual qualified to assess the disability. The candidate is requesting that you provide such documentation. *Please submit your evaluation on professional letterhead stationery attached to this signed statement.*

Your evaluation should include your assessment of the candidate's disability as well as an accommodation plan. *The documentation should explain the type and degree of the candidate's disability, how the proposed accommodation affects the disability, and your recommended accommodations for testing.*

The documents should also include the following information: *(a) the month, day and year this person first consulted you; (b) the month, day and year this person was last seen by you; (c) the diagnosis of this person's disability/impairment; (d) the name of the tests used; and (e) duration of the condition.*

Finally, please sign the statement below and include it in the transmittal of your evaluation.

**PROVIDER DECLARATION**

I hereby certify that the information provided by me is true and is given pursuant to the authorization to release information by my patient. Under penalties of perjury, I declare that the foregoing statements and those in any required accompanying documents or statements are true. I hereby certify that I personally completed this portion of this application and that I may be asked to verify the information provided at any time..

Signature \_\_\_\_\_ Name printed \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ License Number \_\_\_\_\_

If you are not licensed, please note credentials that allow you to diagnosis disabilities/impairments:

\_\_\_\_\_

*Please return this form and attached documentation to:*      AHNCC  
811 Linden Loop  
Cedar Park, Texas 78613

**Office use only:    Date Received** \_\_\_\_\_

