Request for Exam Accommodations Due to Disability

The National Board of Public Health Examiners (NBPHE) will provide reasonable exam accommodations for candidates with disabilities that are covered under the Americans with Disabilities Act (ADA). The ADA defines a person with a disability as someone with a major physical or mental impairment that substantially limits one or more major life activities (i.e., walking, sitting, standing, seeing, hearing, speaking, breathing, learning, working, caring for oneself, and performing manual tasks).

To be completed by the Candidate

If you have need for an accommodation due to a disability covered by applicable law, please complete this form and submit it with your application at least 30 days prior to your requested exam date. The section below must be completed by a qualified professional (see Candidate Handbook for more information). The information in this form, including your need for accommodation and any supporting documentation, will be treated as confidential in accordance with appliable law.

Candidate Name: _____ **Candidate ID:** _____

Exam Name: _____ **Phone:** _____

Email: _____

I have carefully reviewed the information included on this form, certify that it is true and correct to the best of my knowledge, and authorize the release of the information on this form to NBPHE and its testing vendor(s) as deemed necessary by NBPHE to facilitate my request for a testing accommodation.

Candidate Signature: _____ **Date:** _____

To be completed by a Health Care Provider or Other Qualified Professional

The Candidate has requested certain exam accommodation(s) due to their medical condition ("condition"). To evaluate this request, NBPHE requires the candidate to submit this form from a healthcare provider or other qualified professional. Based on your professional assessment, please answer the following questions with as much detail as possible.

I have known _____ **(Candidate) since** _____ **(Date) in**

My professional capacity as a(n): _____

Candidate should return this completed form to: **info@nbphe.org**
If you have questions, call NBPHE at 202-296-3050 or **email info@nbphe.org**

1. **What is the nature and severity of the Candidate's condition, how long has the Candidate had it, and how long is it expected to last? Does the Candidate's condition limit their ability to engage in general life activities? If so, what activities, how is the Candidate limited, and what is the expected duration for the limitation?**

2. **Candidates will be sitting in front of a computer and have 4 hours to take the exam. Does the Candidate's condition limit their ability to take this examination, and if so, how is the Candidate limited, what is the medical reason for the limitation, and what is the expected duration of that limitation?**

3. **What accommodation(s), if any, do you recommend that might alleviate the limitation(s) caused by the Candidate's condition, if any, for purposes of taking this examination?**

Printed Name of Health Care Provider/Professional: _____

Title of Health Care Provider/Professional: _____

Email: _____ **Phone:** _____

Signature of Professional: _____ **Date:** _____

NBPHE does not discriminate against candidates for any NBPHE examination on the basis of any disability covered by applicable law. NBPHE complies with all applicable laws and regulations, including, but not limited to, the Americans With Disabilities Act and equivalent state and local laws. All information provided in this form is for the sole purpose of assessing potential testing accommodations.