INSTRUCTIONS FOR
REQUEST FOR TEST ACCOMMODATIONS FORM

AHCB and PTC support the intent of and comply with the Americans with Disabilities Act (ADA) and will take steps reasonably necessary to make certification accessible to persons with disabilities covered under the ADA. According to the ADA, an individual with a disability is a person who has a physical or mental impairment that substantially limits a major life activity (such as seeing, hearing, learning, reading, concentrating, walking) or a major bodily function (such as neurological, endocrine, or digestive system).

The information you provide and any documentation regarding your disability and test accommodations is confidential and is not included in scoring or reporting.

All approved testing accommodations must maintain the psychometric nature and security of the examination. Accommodations that fundamentally alter the nature or security of the exam will not be granted.

To request test accommodations, follow these 4 steps:

1. Download the Request for Test Accommodations Form, available from Hippotherapy Certification Board
2. Complete Request for Test Accommodations Form with your doctor/healthcare professional.
3. Upload the completed and signed Request for Test Accommodations Form to submit via email with the other application supporting documents (see application instructions).
4. **Deadline**: At least **8 weeks prior to the start of your chosen testing period**, which will be well before the application deadline.
5. Submit the online Exam Application, and **within 24 hours** submit via email the Request for Test Accommodations Form with the other the application supporting documentation.

NOTES:

- Only those requests made and received on the official Request for Test Accommodations Form will be reviewed.
- All requests must be made at the time of application. Accommodations cannot be added to an existing exam appointment.
- If you miss the 8-week deadline, you may not be able to test during your chosen testing period and you will be subject to rescheduling or transfer fees.
- Do not go to www.prometric.com or contact Prometric to request test accommodations as they are not authorized to approve accommodations. All requests for test accommodations must be submitted on the Request Form.
- If you need to use your cell phone or another electronic device to monitor a medical condition, such as diabetes, please be sure to include this on Part 1 of the Request for Test Accommodations Form so that we can notify Prometric in advance.
- Only pre-approved test accommodations will be permitted on the day of the examination. Test center personnel are not authorized to make any changes to the test accommodations on the day of the testing session and any such change may result in your examination score being canceled.

REQUEST FOR TEST ACCOMMODATIONS FORM

This Request for Test Accommodations Form must be completed if you are an individual with a disability covered under the Americans with Disabilities Act (ADA) and would like to request test accommodations. Under the ADA, an individual with a disability is a person who has a physical or mental impairment that substantially limits a major life activity (such as seeing, hearing, learning, reading, concentrating, walking) or a major bodily function (such as the neurological, endocrine or digestive system). The information you provide and any documentation regarding your disability and test accommodations will be held in strict confidence. ***This Form MUST be submitted with your application and received at least 8 weeks prior to the start of your testing period. Forms received after your application has been submitted and less than 8 weeks prior to the start of your testing period may result in a delay in processing or may not be able to be processed for the testing window you applied for.*** The content and validity of the examination shall not be compromised by these accommodations. Part II documentation must be from a non-relative.

Part I – to be completed by the candidate

PLEASE TYPE OR PRINT CLEARLY

_____
Name of Examination

_____
Testing Period

_____
Name (Last, First, Middle Initial)

_____
Address

_____
City *State* *Zip Code*

_____
Daytime Telephone Number

_____
E-mail Address

Have you received the same or similar test accommodations while in an academic setting?

NO _____ YES_____

If yes, provide the year(s) that you received these accommodations. If no, please explain below.

_____

_____

_____

_____

Test Accommodations

I have discussed my Test Accommodations with my qualified healthcare professional and request Test Accommodations as follows: (Check all that apply)

_____Reader

_____Computer Assistance

Extended testing time

☐ One (1) hour

☐ Time and a half

☐ Other (please specify number of hours) _____

_____ Tested separately

_____ Other test accommodations (Please be specific)

_____

_____

_____ I give my permission for my diagnosing professional to discuss with AHCB my records and history as they relate to the requested accommodation.

Signed: _____ Date: _____
Candidate Signature

For Office Use Only
Approved by: _____
Date: _____

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Continue to next page for Part II

REQUEST FOR TEST ACCOMMODATIONS FORM

Part II – Qualified Healthcare Professional Section

This section must be completed by a qualified healthcare professional who is licensed and has expertise in the disability for which these accommodations are sought. The qualified professional must have evaluated the candidate and is familiar with the candidate's condition. Diagnosis of disabilities by family members will not be accepted.

PLEASE TYPE OR PRINT CLEARLY

Professional Documentation

I have evaluated _____ on ____/____/_____ in my capacity as a
Candidate Name *Month Day Year*

_____.
Professional Title

The candidate discussed with me the nature of the examination to be administrated. It is my opinion that, because of this candidate's disability described below, he/she should receive the test accommodations requested. **Please type or print clearly.**

Description of Disability: _____

_____

_____

Diagnosis code(s): _____

Are you licensed to diagnose the disability described in this Form? No _____ Yes _____

Date of disability onset: _____

Major life activity impaired by disability condition: _____

For a diagnosis of generalized anxiety disorder, please provide the additional information

1. Has this person had anxiety for more than 6 months? No____ Yes_____
2. Is the anxiety excessive and interferes significantly with psychosocial functioning? No____ Yes____
3. Does this person have anxiety about a variety of life events or activities? No _____ Yes _____indicate the number of activities impacted: _____
4. Is the anxiety associated with 3 or more of the following: restless, easily fatigued, sleep disturbance, difficulty concentrating, irritability, muscle tension? No___ Yes___

Signed: _____ Title: _____

Qualified Professional's Name (Print Name): _____

Address: _____

_____

Telephone Number: _____ E-mail:_____

Date: _____ License #:_____

Type of license: _____

State in which licensed: _____

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