NORTH DAKOTA
REQUEST FOR ACCOMMODATION (FORM 1404ND)

In compliance with the Americans with Disabilities Act, the HEADMASTER Nurse Aide Testing Program provides accommodations for applicants with disabilities that may affect his or her ability to take the Nurse Aide Competency Exam.

If you are a Candidate with a disability or limitation for which you wish to request an accommodation, please complete both sides of this form and attach the required documentation. This will assist HEADMASTER in determining appropriate accommodations for you. These documents must be submitted to HEADMASTER with your application or retest request. **Accommodations cannot be provided at the test unless this form and all other documentation are received at the time your application or retest request is submitted.**

Social Security Number _____-_____-_____ Email _____

Last_____First_____ Middle_____

Home Address _____City _____ State _____ Zip _____

Home #: (_____) _____-_____ Cell #: (_____) _____-_____ Date of Birth _____/_____/_____

Describe your disability and how this substantially limits one or more of your major life activities:

_____

_____

_____

Explain the nature and extent of your disability and how it impairs your ability to take the test:

_____

_____

_____

Describe the accommodations granted to you during your Nursing Assistant Training Program:

_____

_____

_____

Describe the accommodations you are requesting:

_____

_____

_____

You must submit documentation from a health care provider or learning specialist who rendered a disability or diagnosis. Documentation must include the following:

- ⇒ Description of the disability and limitations related to testing
- ⇒ Recommended accommodation(s)
- ⇒ Name, title, telephone number and signature of the Health Care Provider, Learning Specialist or Instructor
- ⇒ **OR** if you were granted testing accommodations for tests during your Nursing Assistant Training Program, you must complete this form with your primary instructor of the program verifying these accommodations. The primary instructor must sign this form verifying these accommodations.

HEADMASTER will consider all requests on a case-by-case basis. It will be necessary for testing staff to speak and correspond with you regarding specific arrangements. Therefore, it is IMPORTANT that you provide a current address and daytime telephone number and keep the staff informed if these change. You MUST notify the testing staff if you are unable to take the test on the date for which you are scheduled.

In order to provide testing accommodations, HEADMASTER must share the information you provide with the North Dakota Department of Health, the skill test Proctor and the test site coordinator. The information requested above and any documentation regarding your disability is considered strictly confidential and will be shared only with the parties listed above. Your signature below indicates that you understand this and you give permission to HEADMASTER to do so.

SIGNATURES

Candidate Printed Name: _____

Candidate Signature _____ Date _____/_____/_____

I certify that I was the above Candidate's **primary instructor**, and that I provided the accommodations detailed herein during said Candidate's Nursing Assistant Training Program:

Primary Instructor Signature _____ Date _____/_____/_____

***Second Instructor Signature** _____ Date _____/_____/_____

Second signature necessary only if primary instructor was different for classroom and clinical training.