

D&S Diversified Technologies

PO Box #418, Findlay, OH 45839-0418
Toll Free 877-851-2355 – Local 419-420-1605 - Fax 419-422-8328 - www.hdmaster.com

PROVIDING TESTING SOLUTIONS THROUGHOUT OHIO

REQUEST FOR ADA ACCOMMODATION

Form 1402 OL must accompany this form

Applicant: Complete this form ONLY if you have a documented disability.

In compliance with the Americans with Disabilities Act (ADA), the Testing Program provides reasonable accommodations for applicants with disabilities that may affect their ability to take the Lead Competency Examination.

It is your responsibility to notify the Training Program of the needed alternative arrangements. If you have a disability for which you wish to request an accommodation, please provide the following information and return this form as well as all other required documentation to D&S DT with your application. You may attach additional pages if necessary. Accommodations will *NOT* be provided at the examination site unless this form and all other documentation is received at the time of submission of the application. In order to grant testing accommodations, the training program must share information concerning your request. The information requested below and any documentation regarding your disability is considered strictly confidential and will be shared only with the RN Test Evaluator. Please sign your name on this form to indicate your permission for D&S DT to share information about your disability with the RN Test Evaluator.

NAME: _____
(Last) (First) (Middle)

ADDRESS: _____

Daytime Telephone Number: () _____

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 examination:

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Describe the accommodation you are requesting:

REQUIRED DOCUMENTATION FOR ACCOMMODATION REQUESTS:

You are required to submit documentation from the *Health Care Provider* or *Learning Specialist* who rendered a diagnosis. Verification must be submitted to D&S DT on the letterhead stationary of the *Health Care Provider* or *Learning Specialist* and **MUST** include the following:

- (1) Specific description of the disability and limitations related to testing.**
- (2) Specific recommended accommodation.**
- (3) Name, title and telephone number of the *Health Care Provider* or *Learning Specialist*.**
- (4) Original signature of the *Health Care Provider* or *Learning Specialist*.**

If you were granted testing accommodations for an examination, you should submit a letter from the primary instructor of the program verifying these accommodations.

See Form 1404-Supplemental (attached) for additional costs associated with granted accommodations.

NOTE: IN ORDER TO MAKE THE NECESSARY ARRANGEMENTS TO ACCOMMODATE YOUR NEEDS, ALL REQUESTS AND SUPPORTING DOCUMENTATION MUST BE SENT TO D&S DT WITH YOUR APPLICATION. D&S DT MUST APPROVE and arrange for ALL ACCOMMODATIONS PRIOR TO YOUR TEST DATE.

D&S DT will consider all requests on a case-by-case basis. It will be necessary for D&S DT 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 D&S DT staff informed if these change. You will receive written confirmation of your approved accommodations. You ***MUST*** notify the D&S DT staff if you are unable to take the examination on the date for which you are scheduled.

SIGNATURE: _____ DATE: _____

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D&S Diversified Technologies TESTING AND REGISTRY ACCOMMODATION APPLICATION Supplemental

- This APPLICATION MUST ACCOMPANY FORM 1402 OL
- Applications must be received in the Findlay office 10 working days prior to requested test date.
- Accommodations are granted in accordance with the Americans with Disabilities Act
- Typically accommodations would be used during training in order to be approved for testing.

Social Security Number: _____ - _____ - _____ Date of Birth: _____

Name: _____
Last First Middle Maiden/Former

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Special Accommodation Requested:

____ Reader Marker ____ Additional Testing Time ____ Large Print

____ Other, please explain _____

Include an additional \$50.00 per individual to help offset the additional cost the accommodation will impose as an undue hardship on the normal testing operation. If no accommodation is granted the \$50 will be refunded. (See form 1402 OL)

OFFICIAL USE ONLY: SITE # _____ PACKET# _____ TEST DATE _____ SCHEDULER: _____ TEST EVALUATOR _____ DATE ACCOMMODATION Granted: _____ OTHER: _____ DATE ACCOMMODATION Denied: _____
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