HEADMASTER LLP

3310 McHugh Dr, Hel ena, MT 59602

Toll Free 800-393-8664 - Local 406-442-8656 · Fax 406-442-3357 - www.hdmaster.com

PROVIDING Medication Aide (MA) TESTING SOLUTIONS THROUGHOUT the United States

REQUEST FOR ADA ACCOMMODATION

Form 1101 RM and Form 1402 RM 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 Medication Aide (MA) Testing Program provides reasonable accommodations for applicants with disabilities that may affect their ability to take the Medication Aide Competency Examination (MACE). It is your responsibility to notify the MA testing program of the needed alternative arrangements. If you have a diagnosed 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 are received with your application. In order to grant testing accommodations, the MA testing staff must share information concerning your request with the test proctor who will be administering your examination. The information requested below and any documentation regarding your disability is considered strictly confidential and will be shared only with the Test Proctor, necessary test team members and Arkansas State Agencies. Please sign your name on this form to indicate your permission for D&S DT to share information about your disability with the Test Proctor, necessary test team members, and State Agencies.

Name:			Social Security #:	
· · · · · · · · · · · · · · · · · · ·		First	·	
Address:				
	Street	3	State	1
Phone:		Work Phone:	Dat	te of Birth:
Reader Market	r Additional Tim	ne Large Print Oth	er please explain:	
Describe your disa	bility and how this s	substantially limits one or	more of your major life a	activities:
Explain the nature	and extent of your d	lisability and how it impair	rs your ability to take the	e MA examination:
Describe the accor	nmodation you are r	equesting:		
Describe the accor	nmodations granted	to you during your Medic	ation Aide Training Prog	gram:

D&SDT Form 1404 RM Updated: 4/13/2006 Printed: 4/13/2007

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PROVIDING Medication Aide (MA) TESTING SOLUTIONS THROUGHOUT the United States REQUIRED DOCUMENTATION FOR ADA 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.

Applicants Signature:

- (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*.

OR, if you were granted testing accommodations for testing during your Medication Aide Training Program, you must complete this form with your Primary Instructor verifying these accommodations. The Primary Instructor **must** sign this form verifying any provided training accommodations. Your signature below indicates that you understand this application and the documentation you included and give permission to HEADMASTER, your Written Test Proctor and appropriate Arkansas State Agencies to be informed of accommodations requested. The information requested and 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 share this information as described.

Primary Instructor Signature:	Phone:	Date:
NOTE: IN ORDER TO MAKE THE NECESSA REQUESTS AND SUPPORTING DOCUME APPLICATION. D&S DT and the ASBN MUST TO YOUR TEST DATE.	ENTATION MUST BE SENT T	O D&S DT WITH YOUR
D&S DT will consider all requests on a case-to-correspond with you regarding specific arrangement	•	
of any approved or denied accommodations. Y	DT informed if these change. You w You <u>MUST</u> notify the testing staff i	rill receive written confirmation
and daytime telephone number and keep the D&S of any approved or denied accommodations. Y examination on the date for which you are schedule SIGNATURE:	DT informed if these change. You wo wou MUST notify the testing staff i ed.	ill receive written confirmation f you are unable to take the
of any approved or denied accommodations. Y examination on the date for which you are schedule SIGNATURE:	DT informed if these change. You wo wou MUST notify the testing staff is ed.	rill receive written confirmation f you are unable to take theDATE:
of any approved or denied accommodations. Y examination on the date for which you are schedule	DT informed if these change. You we'ou <u>MUST</u> notify the testing staff is ed.	rill receive written confirmation f you are unable to take theDATE:SCHEDULER:

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