

HEADMASTER LLP

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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 stationery 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*.**

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.

Applicants 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 Medication Aide Training Program.

Primary Instructor Signature: _____ **Phone:** _____ **Date:** _____

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 and the ASBN 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 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 D&S DT informed if these change. You will receive written confirmation of any approved or denied accommodations. You **MUST** notify the testing staff if you are unable to take the examination on the date for which you are scheduled.

SIGNATURE: _____ TITLE: _____ DATE: _____

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