D&S Diversified Technologies LLP Headmaster LLP	D&S Diversified Technologies LLP P.O. Box 418, Findlay, OH 45839-0418 877-851-2355 – Fax: 419-422-7395 www.hdmaster.com	*Innovative, quality technology solutions throughout the United States since 1985.*

Form 1404 MP Updated: 2/08/2012

MASSACHUSETTS MAP TESTING PROGRAM
REQUEST FOR ADA ACCOMMODATION (FORM 1404 MP)

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

In compliance with the Americans with Disabilities Act (ADA), the MAP Testing Program provides reasonable accommodations for applicants with disabilities that may affect their ability to take the MAP Competency Examination. It is your responsibility to notify the MAP testing program of the needed alternative arrangement(s). 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&SDT. 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 with your application and the requested accommodation is granted prior to testing. In order to grant testing accommodations, the MAP testing staff must share information concerning your request with the RN observer or knowledge test proctor who will oversee your manual skill/transcription test or computer based knowledge test. The information requested below and any documentation regarding your disability is considered strictly confidential and will be shared only with individuals on a need to know basis and appropriate Massachusetts State Agencies. Please sign your name on this form to indicate your permission for D&SDT to share your information appropriately as described.

*********** (Any specialized equipment required must be provided by the candidate)***********

Name:______________________________________ Social Security#:________-________-___________
Last First

Address:____
Street City State Zip

Phone:________________ Phone #2: ________________________Date of Birth:________________

___Reader Marker ___ Additional Time___ Large Print___ Other please explain:____________________

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Describe your disability and how this substantially limits one or more of your major life activities:
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Explain the nature and extent of your disability and how it impairs your ability to take the MAP examination(s):
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Describe the accommodation(s) you are requesting:

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Describe the accommodation(s) granted to you during your MAP Training Program:

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REQUIRED DOCUMENTATION FOR ADA ACCOMMODATION REQUESTS:

You are **required** to submit documentation from the *Health Care Provider* or *Learning Specialist* who rendered an ADA diagnosis. Verification must be submitted to D&SDT 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 any test accommodation(s) during your MAP Training Program, you must complete this form with your Primary Instructor verifying any accommodation(s) granted. The Primary Instructor **must** sign this form verifying any provided training accommodation(s). Your signature below indicates that you understand this application and all documentation you included and you give permission to D&SDT staff, the RN Test Observers, Written Test Proctors, Actors, and appropriate Massachusetts State Agencies to be informed of accommodation(s) requested. The information requested and documentation regarding your disability is considered strictly confidential and will be shared only with the parties listed on a need to know basis. Your signature below indicates that you understand and give your permission to D&S Diversified Technologies LLP to share this information appropriately. I am aware that there are extra costs associated with providing reasonable accommodations for testing and that I am expected to notify D&S at least at least 72 hours before my scheduled examination or as soon as I become aware at 877-851-2355.

Applicant's Signature:_________________________________Date:_________________________

I certify that I am/was the above listed candidate's Primary Instructor, and that I provided the accommodation(s) detailed herein during the candidate's 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&SDT ALLOWING A SUFFICIENT TIME FRAME FOR D&SDT STAFF TO REVIEW, APPROVE AND ARRANGE FOR ACCOMMODATION GRANTED OR DENY YOUR REQUEST ALL PRIOR TO ANY TEST DATE ANTICIPATED.

All requests will be considered 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 D&SDT 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: _______________