

D&S DIVERSIFIED TECHNOLOGIES LLP dba HEADMASTER LLP
PO BOX 6609 HELENA MT 59604
TELEPHONE: 800-393-8664 FAX: 406-442-3357
EMAIL: hdmaster@hdmaster.com
WEB SITE: www.hdmaster.com

REQUEST FOR ADA ACCOMMODATION

Form 1101 MT-CMA and form 1402 MT-CMA 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 Testing Program provides reasonable accommodations for applicants with disabilities that may affect their ability to take the Medication Aide Competency Examination (MACE) examination. It is your responsibility to notify the MA 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 HEADMASTER 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 at the time of submission of the application. In order to grant testing accommodations, the MA staff must share information concerning your request with the WTP who will proctor your written examination. Any information requested below and any documentation regarding your disability is considered strictly confidential and will be shared only with the Written Test Proctor and Montana State Agencies as necessary. Please sign your name on this form to indicate your permission for HEADMASTER to share information about your disability with the WTP and Montana State Agencies as necessary.

CANDIDATE INFORMATION

Last _____	First _____	Middle _____
Address _____	City _____	State _____ Zip _____
Daytime Home Telephone (_____) _____ - _____		

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 MA 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 HEADMASTER 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 a testing accommodation for examination during your basic Medication Aide Training Program, 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 HEADMASTER WITH YOUR APPLICATION. HEADMASTER MUST APPROVE and arrange for ALL ACCOMMODATIONS PRIOR TO YOUR TEST DATE.

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 us informed if these change. You will receive written confirmation of any approved accommodations. You **MUST** notify us if you are unable to take the examination on the date for which you are scheduled.

SIGNATURE

Candidate Signature _____ Date ____/____/____
Print Candidate Name _____

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TESTING AND REGISTRY ACCOMMODATION APPLICATION SUPPLEMENTAL

DIRECTIONS

1. This application must accompany Form 1101MT-CMA and 1402MT-CMA
2. 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.
3. Applications must be received in the office 10 working days prior to requested test date.
4. Accommodations are granted in accordance with the Americans with Disabilities Act
5. Typically any accommodations granted would have also been used during training.

CANDIDATE INFORMATION (PLEASE PRINT)

Social Security Number _____ - _____ - _____	Email _____		
Last _____	First _____	Middle _____	
Address _____	City _____	State _____	Zip _____
Home Telephone (_____) _____ - _____	Date of Birth _____/_____/_____		

SPECIAL ACCOMMODATION REQUESTED

Reader Marker <input type="checkbox"/>	Additional Testing Time <input type="checkbox"/>	Large Print <input type="checkbox"/>
Other, please explain _____		
