NBCOT®
National Board for Certification in Occupational Therapy

Certification Exam Testing Accommodations Request Form

ID 71 rev011325

Dear Healthcare Professional:

The exam candidate identified below is requesting testing accommodations to take a National Board for Certification in Occupational Therapy, Inc. (NBCOT®) Certification Examination and is submitting documentation prepared by you in connection with their request.

NBCOT requires supporting documentation from qualified healthcare professional(s) licensed and/or certified to assess, diagnose, and treat the applicant's relevant disability.

Exam Candidate Information

Candidate Name: _____ **Birth Date (MM/DD/YYYY):** _____

Healthcare Professional Contact Information

(To be completed by the healthcare professional.)

Name: _____ **Title/Occupation:** _____

Address: _____

City: _____ **State/Country:** _____ **Postal Code:** _____

Phone: _____ **Email:** _____

Licensure/Certification Information

(To be completed by the healthcare professional.)

License/Certification Number: _____ **State/Country:** _____ **Expiration Date:** _____

Disability Diagnosis

(To be completed by the healthcare professional.)

Disability Diagnosis	DSM/Diagnostic Code	Diagnosis Date

Disability Impact

(To be completed by the healthcare professional.)

Describe how the candidate's disability substantially limits one or more major life activities (such as seeing, hearing, learning, reading, concentrating, or thinking) or a major bodily function (such as the neurological, endocrine, or digestive system) when compared to most people in the general population.	

Explain how the candidate's disability impairment impacts their ability to test under NBCOT's standard testing conditions, as described on ***page 4*** of the ***Testing Accommodations Handbook***. ***(Standard exam is 4-hour computer-based exam taken in a reduced-distraction testing center.)***	

Prior Testing Accommodations

(To be completed by the healthcare professional.)

Document testing accommodations approved for prior standardized testing (e.g., SAT, GRE, LSAT, MCAT, college exams). **If no prior accommodations exist,** the qualified healthcare professional should explain why no accommodations were given in the past and are needed now.	

Testing Accommodations Recommendation(s)

(To be completed by the healthcare professional.)

Please document specific recommendations for reasonable testing accommodations based on the candidate's disability diagnosis and explain why each accommodation is necessary to minimize the impact of disability while taking an NBCOT® exam.

- If any time-related accommodations are recommended, the recommendation(s) must clarify if additional time is necessary due to the need for stop-the-clock breaks and/or an exam time extension.
- Time-related recommendations must be specific and quantitative on duration (ex. 30 minutes, 1.25x) and avoid non-specific recommendations like "extra, extended, additional, more" time.
- A "limited or reduced distraction" or "distraction-free" environment and a separate room are not one in the same. Pearson VUE's standard testing environment provides a quiet, reduced/limited distraction test space at all test centers. The standard environment is an individual cubicle desk (to minimize distractions) with other test takers in the testing room (refer to *page 4* of the *Testing Accommodations Handbook*). Earplugs and noise reducing headphones are available at all Pearson Professional Centers and Pearson VUE Authorized Test Center Selects. A separate room is not soundproof and does not guarantee a distraction or noise free environment.

Specific recommendation(s) for reasonable testing accommodations	Explanation why this accommodation is necessary to minimize the impact of disability while taking an NBCOT® exam

Declaration

(To be completed by the healthcare professional.)

IMPORTANT — This document is considered void without the healthcare professional's signature and one of the following:

- **Digital signature with timestamp (such as DocuSign),**
- **A cover letter on practice letterhead to accompany this form,**
- **An official office stamp (see below)**

I hereby certify that the above information is true and is given pursuant to the authorization to release information by the above-named candidate. I attest I have specific training and experience in the assessment, diagnosis, and treatment of the disability identified above. I hereby certify I personally completed this form and provided specific recommendations for reasonable testing accommodations for the NBCOT exam. I may be asked by NBCOT to verify the above information at any time.

Signature of Healthcare Professional: _____

Printed Name of Healthcare Professional: _____

Date: _____

Office Stamp