NBCOT®
National Board for Certification in Occupational Therapy

Testing Accommodations Request Form

ID 71 rev121423

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 affects one or more major life activities (outside of testing) as 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 outlined in the "Exam Day: Questions and Answers" section of the *Certification Exam 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 what testing accommodations have been approved for prior standardized testing (e.g., SAT, GRE, college exams). If no prior accommodations exist, the qualified healthcare professional should include an explanation as to 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 applicant's disability diagnosis along with an explanation of why each accommodation is necessary to minimize the impact of disability while taking an NBCOT® exam.

- If an exam time extension is recommended, please **be specific (e.g., one additional hour, time and a half), avoiding non-specific** recommendations like "extra, additional, more, extended".
- If extra time is intended for stop the clock breaks rather than additional exam time, this should be specifically stated.

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

Declaration

(To be completed by the healthcare professional.)

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.

IMPORTANT — This document is considered void without the healthcare professional's signature.

This document must include one of the following: digital signature with timestamp, a cover letter on practice letterhead to accompany this form, or official office stamp below.

Signature of Healthcare Professional: _____

Printed Name of Healthcare Professional: _____

Date: _____

Office Stamp