



National Board for Certification  
in Occupational Therapy

# Testing Accommodations Request Form

ID 71 rev091923

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

Disability Diagnosis	DSM/Diagnostic Code	Diagnosis Date

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## Disability Impact

*(To be completed by 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.	
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Explain how the candidate's disability impairs their ability to test under NBCOT's standard testing conditions, as outlined in the "Exam Day: Questions and Answers" section of the <a href="#"><i>Certification Exam Handbook</i></a> . <i>(Standard exam is 4-hour computer-based exam taken in a reduced-distraction testing center.)</i>	
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Document what testing accommodations have been approved for prior standardized testing. 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.	
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## Testing Accommodations Recommendation(s)

*(To be completed by 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 extra time is intended for stop the clock breaks rather than additional exam time, this should be specifically stated.
- If an exam time extension is recommended, please **be as specific as possible, avoiding non-specific** recommendations like “extra, additional, more, extended”.

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

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## Declaration

*(To be completed by 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 must include a cover letter on practice letterhead with signature, or an official office stamp below.**

**Signature of Healthcare Professional:** \_\_\_\_\_

**Printed Name of Healthcare Professional:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Office Stamp

