NHA Request for Accommodations

Accommodations may be available to individuals with documented disabilities pursuant to the Americans with Disabilities Act (ADA). NHA provides reasonable testing accommodations to candidates whose documented disabilities or other qualifying medical conditions hinder their ability to take the examination under standard conditions. To be considered for special accommodations, please complete the form below. Please be aware that submission of a request for an accommodation does not guarantee testing accommodations. Decisions will be made on a case-by-case basis considering the information submitted and in accordance with the law.

Requests for accommodations will be processed as quickly as possible. Candidates should allow for a minimum of 30 days for processing, with the understanding that some cases may take longer. Candidates must receive written confirmation that accommodations have been granted **before** they schedule an exam. Therefore, we strongly encourage candidates who are in need of an accommodation to submit their request and documentation well in advance of any exam registration deadlines. Candidates will be notified in writing of the decision regarding their request for an accommodation.

Candidates who receive a testing accommodation are subject to the same policies as all other exam takers. NHA reserves the right to make final judgment regarding testing accommodations.

Attachment instructions

1. Attach a letter from a physician or healthcare professional qualified to diagnose the disability or medical condition and to render an opinion as to the need for an accommodation. The letter must have been written on official stationery **no more than 2 years ago** and must include the following elements:
    a. The specific disability/diagnosis. Mental/emotional disabilities must be accompanied by a numerical DSM-IV classification code.
    b. The identity of the health care professional who made the diagnosis (if different from the professional providing the requested information).
    c. The approximate date when the disability was first diagnosed.
    d. The approximate duration of the disability.
    e. The method used to make the diagnosis.
    f. A brief explanation of how this condition limits the candidate's ability to take the exam under standard conditions.
    g. Specific accommodations required. These accommodations should be adequate without creating an unfair advantage. Please note that candidates who require extra time to complete the exam will be given 1 1/2 times the standard allotted time. If more time is needed, the letter must specifically state how much time is needed and why that amount of time is required.
    h. An electronic or original signature of the professional providing the above information.
    i. The professional's name (legibly written or typed), license number, state of licensure, title, phone number, and address.
2. Attach the Request for Accommodations Form (follows).
3. Submit both the letter and the Request for Accommodations Form to National Healthcareer Association via mail or fax:

Mail
Attn: Compliance (R&D)
NHA
7500 W 160th Street
Stilwell, KS 66085

Fax
913-685-2381

NHA REQUEST FOR ACCOMMODATIONS FORM

(TO BE COMPLETED BY THE CANDIDATE)

Date:	
Name (Last/First/M.I.):	
Last 4 digits of SSN:	
Street address:	
City/State/Zip:	
Daytime phone:	
E-mail address:	
Return fax:	
Exam name:	
Description of disability:	
Accommodations requested:	
Accommodations granted in the past:	
Date:	
Organization:	
Test:	
Accommodation:	

Under penalty of perjury, I declare that the representations that I have made in this Request for Accommodations and any supporting documentation are true to the best of my knowledge. I understand that false information may result in the denial or revocation of accommodations and/or certification. I hereby certify that I personally completed this form and that I may be asked to verify this information at any time. I understand that NHA reserves the right to make additional inquiries regarding my disability and previous accommodations before rendering a decision.

If clarification or further information is required, I authorize NHA to communicate with the professional(s) who diagnosed the disability, the professional(s) who provided information related to my Request for Accommodations, and any entities that have granted accommodations to me in the past. I understand that NHA may request additional documentation from the persons and/or entities referenced above and/or from myself. I also authorize NHA to release this information to a professional chosen by NHA for the purpose of conducting an independent evaluation of the accommodations that have been requested. I acknowledge that such processes may require extra time for the accommodation to be granted.

______________________________ ______________________________

Candidate's signature Date

This form will be valid for **one year** from the date of the candidate's signature.