

ADA Examination Accommodation Request

The Americans with Disabilities Act (ADA) requires that reasonable accommodations be provided to qualified individuals with disabilities. This law defines disabilities as physical or mental impairments that substantially limit one or more of a person's major life activities (e.g., walking, hearing, speaking, seeing, reading, or writing). The Board will provide reasonable and appropriate accommodations to qualified candidates who have documented disabilities and demonstrate a need for accommodation during the examination.

To support a request for test accommodations, please complete, print, and mail this application to the Iowa Board of Pharmacy, 400 SW 8th Street, Suite E, Des Moines, Iowa 50309-4688.

Also, provide current (not more than three years old) written supporting documentation from a qualified health professional which addresses the issues listed below.

Application for Disability Accommodation Pharmacy Licensing Examinations

PART I: APPLICANT'S STATEMENT

Name: _____

Address: _____

Social Security #: _____

Telephone Number: _____

Birthdate: _____

Examinations: NAPLEX MPJE OTHER

1. Specifically describe the accommodation you seek:

2. Specifically identify the physical or mental disability that you believe requires this accommodation:

If you have previously been provided with test accommodation(s), please list the provider and describe the accommodation(s): _____

Physician, Therapist, or Other Health Care Practitioner(s):

Name(s): _____

RELEASE

I authorize the practitioner(s) listed above to release to the Board of Pharmacy or its legal representative any and all information in his or her possession about my disability above. "Information" means all information in the possession of, or derived from, providers of health care regarding my medical history, mental or physical condition, or treatment. I agree that this authorization shall be valid until cancelled in writing by me. I understand that the Board of Pharmacy will use the information obtained by this authorization to determine eligibility for a reasonable accommodation with regard to the pharmacist licensure examination by reason of my disability. The Board reserves the right to require additional information or documentation to support this request for accommodation. The Board will not release any information obtained to any person or organization, except to NABP (the test developer), or any government agency that may be involved with my application to take the pharmacist licensure examination. Under penalties of perjury, I declare that the foregoing statements and those in any accompanying documents or statements are true. I understand that false information may be cause for denial or loss of a licensure. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time.

Signature: _____ Date: _____

State of _____

County of _____

Subscribed and sworn to before me this _____ day of _____, 200__ by _____.

Notary Public
My commission expires _____

PART II: QUALIFIED HEALTH PROFESSIONAL'S SUPPORTING DOCUMENTATION:

1. Include a statement of the specific diagnosis of the disability.
2. Cite the diagnostic criteria and tests given, with dates, results, and interpretations. Cite how the results support the diagnosis.
3. Describe the candidate's functional limitations due to the disability, and the impact of those limitations on physical, perceptual and cognitive abilities.
4. Recommend specific accommodation(s) and for each accommodation, provide a rationale as to how it will reduce the impact of the functional limitation(s).
5. State your professional credentials, training, work experience and any licenses you hold that support your qualifications to diagnose and/or treat this candidate's disabilities.
6. If no prior accommodations have been made for this candidate, explain why. If they have – state what was done and provide past documentation of prior accommodations.