REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by the Americans with Disabilities Act, please complete this form and have your healthcare provider complete the Documentation of Disability-Related Needs and submit it prior to scheduling your CPH exam. Do not schedule your exam until your accommodations have been approved. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality.

Candidate Information

Name (Last, First, Middle Initial, Former Name)

Mailing Address

City State Zip Code

Daytime Telephone Number Email Address

Special Accommodations

I request special accommodations for the Certified in Public Health examination.

Please provide (check all that apply):

_____ Reader
_____ Extended testing time (time and a half)
_____ Reduced distraction environment
_____ Please specify below if other special accommodations are needed.

Comments:

__________________________________________________________

PLEASE READ AND SIGN:

I give my permission for my diagnosing professional to discuss with NBPHE and Scantron staff my records and history as they relate to the requested accommodation.

Signature: ____________________________ Date: ________________

Return this form to: info@nbphe.org
If you have questions, call NBPHE at 202-296-3050 or info@nbphe.org.
DOCUMENTATION OF DISABILITY- RELATED NEEDS

Please have this section completed by an appropriate professional (education professional, physician, psychologist, psychiatrist) to ensure that NBPHE and Scantron are able to provide the required accommodations.

Professional Documentation

I have known candidate name since / / in my capacity as 

Candidate Name

Date

My Professional Title

The candidate discussed with me the nature of the test to be administered. It is my opinion that, because of this candidate’s disability described below, he/she should be accommodated by providing the special arrangements listed on the reverse side.

Description of Disability:

Signed: ________________________________

Title: ________________________________

Printed Name: ________________________________

Address:

Telephone Number: ________________________________ Email Address: ________________________________

Date: ________________________________ License # (if applicable): ________________________________

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