Request for ADA Testing Accommodations for Colorado, Florida, Maine, Oregon, and Utah Candidates Pharmacist Licensing Examinations

At the request of the boards of pharmacy in Colorado, Florida, Maine, Oregon, and Utah, the National Association of Boards of Pharmacy® (NABP®) will evaluate testing accommodation requests for the North American Pharmacist Licensure Examination® (NAPLEX®) and the Multistate Pharmacy Jurisprudence Examination® (MPJE®).

Instructions

Complete all three parts of the form in their entirety and include all supporting documentation as required.

- Part I: Candidate Statement
- Part II: Practitioner's Statement
- Part III: Academic/College Statement
  If you have graduated from pharmacy school more than three years ago, or if you have achieved FPGEC® Certification, Part III: Academic/College Statement does not need to be completed.

Additional details are available in the Candidate Registration Bulletin.

You may email the Request form to ADArequest@nabp.pharmacy. The form and supporting documentation may also be mailed in one envelope to:

NABP Competency Assessment Department
Colorado, Florida, Maine, Oregon, and Utah Candidates
1600 Feehanville Dr
Mount Prospect, IL 60056

You should retain a copy of the completed form for your records.

Review and Approval Process

All requests for testing accommodations for examination candidates will be evaluated and authorized by NABP. NABP will notify you if your request is approved; however, candidates approved for testing accommodations may not schedule examinations directly with Pearson VUE until they are instructed to do so by NABP. Once notified by NABP, candidates must schedule their testing appointment with Pearson VUE.

During the evaluation process, NABP may contact the candidate, practitioner, or school if more information is required to support the request form. NABP may share information that a candidate provides, including but not limited to, the request form, the candidate's medical history, the nature of the diagnosis(es), the accommodations provided in the academic environment, and the health care provider's statement.

Validity Periods

Accommodations approval is valid for one year from the date of notification of approval to the candidate. For Colorado, Florida, Maine, Oregon, and/or Utah candidates, a completed request form, including the authorization and release and attestation, shall remain valid for a period of three years from the date when first executed by the candidate unless earlier revoked by the candidate in a written notification sent to NABP. The form will be considered for any NABP examination occurring within the validity period; however, NABP reserves the right to require additional documentation or modify the approved accommodations. Candidates must resubmit documents if their disability status or requested accommodation(s) changes.

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PART I: CANDIDATE STATEMENT

Please type or print the requested information, unless a signature is required. *Enter name exactly as it appears on your ID, including first, middle or initial(s), and last names including any suffixes.

Name: _____ _____ _____

Address: _____

_____

NABP e-Profile ID: _____ Telephone Number:_____

Birth Date: _____ Examination: ☐ NAPLEX ☐ MPJE

Briefly describe the disability: _____

_____

Please attach a detailed written summary which describes your disability, justification for the requested accommodation(s) and current treatment/therapy prescribed or recommended for the disability (eg, medication regiment, physical aids).

List each practitioner (eg, physician, therapist). Attach additional sheets if necessary.
Each treating practitioner must complete Part II: Practitioner's Statement.

Name: _____

Office Address: _____

Telephone Number: _____ Length of Time as Patient: _____

If you have previously been provided with testing accommodation(s), please list the provider, the time frame, and description of accommodations. If no accommodations were provided to you in the past, please provide a written explanation of why accommodations are requested now and why they were not requested in the past.

_____

_____

Authorization and Release and Attestation:

I authorize each treating practitioner listed above to release to the Board of Pharmacy and/or the National Association of Boards of Pharmacy® (NABP®) or its legal representative any and all information about my disability described above. "Information" means all information in the possession of, or derived from, treating practitioners or providers of health care in connection with the disability for which I am requesting accommodations. I agree that this authorization, release and attestation (AR&A) shall be valid for three years unless earlier revoked in writing by me. I understand that NABP will use the Information obtained by this AR&A to review my accommodation request in connection with an NABP examination for which I request accommodations during the validity period of this AR&A. The Board of Pharmacy and/or NABP reserves the right to require additional information or documentation to support this request for accommodation or to obtain an independent assessment by another health care professional or treatment provider. Under penalties of perjury, I swear that the foregoing statements and those in any accompanying documents or statement are true, correct and complete. I understand and agree that false, incomplete, or inaccurate information may be cause for NABP to invalidate the NABP examination score or results; delay or deny access to the NABP examination; or deny access to other NABP programs, NABP assessments, or NABP examinations such as the NAPLEX and MPJE, in addition to any other remedies available under law. I hereby attest and warranty that I personally completed this request form and that I may be asked to verify the above information at any time.

Signature: _____ Date: _____

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PART II: PRACTITIONER'S STATEMENT

Each treating practitioner must complete Part II: Practitioner's Statement and return it along with all supporting documentation to the candidate. Please type or print the requested information, unless a signature is required.

Practitioner Name: _____

Professional Title: _____

Professional Training, Credentials, Licensing, and Specialization to Support Relative Diagnoses and Appropriate Recommendation (please attach appropriate written documentation citing credentials):

_____

_____

_____

Office Address: _____

Telephone Number: _____ State License Number: _____

Patient's Name: _____Patient's Address: _____

Date Patient First Consulted: _____ Date Patient Last Consulted: _____

Number of Years as a Patient: _____

Diagnosis of Disability: _____

_____

_____

Recommended Accommodation(s): _____

I. Please attach a written statement explaining the diagnosis and its impact on the candidate's abilities relative to the request for special accommodations. *(In order to ensure that a current diagnosis is presented, it is preferred that the evaluations have been conducted within the past three to five years. Please provide an explanation of any gaps in medical evaluations taking place prior to request for accommodations.)*

II. Please attach a written explanation for each recommended accommodation(s), including the current treatment for the disability (eg, any medication management or physical aids). Any current and applicable test used to support the diagnosis or recommendation for accommodations should be submitted.

III. If no accommodations were provided to the candidate in the past, please provide a written explanation of why accommodations are requested now and why they were not requested in the past.

Certification

I hereby certify that the above information is true and is provided pursuant to the authorization to release information by my patient. I also certify that I have the necessary specialized training to make the above diagnosis, that I personally examined the candidate named above, and that the above diagnosis and assessment of the accommodation request is my professional judgment. I understand that National Association of Boards of Pharmacy® (NABP®) may contact me (with the candidate's permission) to obtain further information if necessary, and that NABP may obtain an independent assessment by another professional.

Practitioner's Signature: _____ Date: _____

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PART III: ACADEMIC/SCHOOL STATEMENT

The candidate named below will be sitting for an upcoming pharmacist licensing examination(s) and is requesting accommodations for testing for the North American Pharmacist Licensure Examination® or Multistate Pharmacy Jurisprudence Examination®. Please type or print the requested information, unless a signature is required. Please complete this form and return it and all supporting documentation to the candidate.

I authorize the designated school to provide information regarding the accommodations I received in school:

_____ _____

Candidate Name (please print) Candidate Signature

School Statement

School Name: _____

Name of Person Completing Form: _____ Title: _____

Address: _____ Phone Number: _____

Time period student was affiliated with the School: _____

Please describe the accommodation(s) and the basis for the approval of the accommodation(s).

_____

_____

_____

_____

Month/Year Accommodations Started and Ended: _____

The accommodation was _____ a one-time event or _____an ongoing accommodation. (Select one.)

Please attach any testing results or recommendations from a qualified practitioner used to determine the accommodations provided.
Please list the information/documentation that was the basis for this approved accommodation:

_____

_____

_____

_____

Certification

I hereby certify that I am an authorized representative of the school or college of pharmacy (School) and that the above information is true and is provided pursuant to the authorization and release signed by the candidate named above. I understand that NABP may contact me or other School representatives to obtain further information if necessary.

School Official's Signature: _____ Date: _____