Request for Testing Accommodations
NABP Examinations

The Request for Testing Accommodations form (Form) is provided to assist the board of pharmacy, the school of pharmacy, and/or the National Association of Boards of Pharmacy® (NABP®) in evaluating a request for testing accommodations under the Americans with Disabilities Act (ADA).

Instructions

Download, complete, and submit all three parts of the fillable Form as applicable, including supporting documentation in its entirety as required. Retain a copy for your records.

- Part I: Candidate Statement, **including detailed written summary of disability**
- Part II: Practitioner Statement, **including practitioner's supporting written summary(ies)**
- Part III: Academic, Institution, School, or College Statement
  If you did not receive accommodations in pharmacy school, graduated from pharmacy school more than three years ago, or achieved Foreign Pharmacy Graduate Examination Committee™ (FPGEC®) Certification, Part III: Academic, Institution, School, or College Statement does not need to be completed.

Additional details are available in the *NAPLEX/MPJE Candidate Application Bulletin,* the *FPGEC Candidate Application Bulletin,* and the Programs section of the NABP website at *www.nabp.pharmacy.*

Submission, Review, and Approval Processes

The process for the Pharmacy Curriculum Outcomes Assessment® (PCOA®) differs from that of the North American Pharmacist Licensure Examination® (NAPLEX®), Multistate Pharmacy Jurisprudence Examination® (MPJE®), and Foreign Pharmacy Graduate Equivalency Examination® (FPGEE®), as explained below.

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

NAPLEX/MPJE Candidates Seeking Licensure in District of Columbia and Virginia

Upload the completed Form and supporting documentation in your NABP e-Profile account during the online application process for examinations. Please also visit the appropriate board of pharmacy website to ensure that you understand specific requirements for the state, including the provision of state-specific documentation, if any. Your completed Form, supporting documentation, and state-specific documentation will be reviewed by NABP and the board of pharmacy. NABP will contact you after the review of your request is completed. Candidates whose requests have been approved may schedule their testing appointment with Pearson VUE.

NAPLEX/MPJE/FPGEE Candidates

Upload the completed Form and supporting documentation in your NABP e-Profile account during the online application process for examinations. These requests will be reviewed by NABP. NABP will contact you after the review of your request is completed. Candidates whose requests have been approved must schedule their testing appointment with Pearson VUE.

PCOA Candidates

Complete Parts I and II and submit the Form and supporting documentation to your school of pharmacy. The school of pharmacy will complete Part III and forward the request to NABP by uploading the Form and supporting documentation to your NABP e-Profile. Once the request is approved, the school of pharmacy may notify the candidate.

Validity Periods

Accommodations approval is valid for one year from the date of notification of approval to the candidate. The Form may be considered for any NABP examination occurring within the validity period. Candidates must resubmit a new Form and supporting documents if their disability status or requested accommodation(s) changes. NABP may require additional documentation or modify formerly approved accommodations.

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PART I: INDIVIDUAL/CANDIDATE STATEMENT

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

Name:_____

Address: _____

_____

e-Profile ID Number:_____Telephone Number: _____

Birth Date:_____Examination Applying for: ☐ NAPLEX ☐ MPJE ☐ PCOA ☐ FPGEE

Date the PCOA was taken (if applicable)_____Accommodations used for the PCOA _____
Month, Year

Briefly describe the disability: _____

_____

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

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 a description of the 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, Release, and Attestation:

I hereby authorize each treating practitioner listed herein to release to and discuss with the school or college of pharmacy at which I am enrolled (School), Board of Pharmacy (Board), and the National Association of Boards of Pharmacy® (NABP®) and its ADA Committee any and all Information about me or my disability described herein. "Information" means all information about me 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 further authorize NABP, School, and Board (individually "Organization" and two or more are, collectively, "Organizations") to discuss Information with an Organization, Organizations, or an Organization or Organizations may discuss Information with a treating practitioner. I agree that this authorization, release, and attestation (AR&A) shall be valid for one year, unless earlier revoked in writing by me. I understand that an Organization may use the Information obtained pursuant to this AR&A to review my accommodation request in connection with any NABP examination for which I request accommodations during the validity period of this AR&A. The Board of Pharmacy and NABP reserve 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. I hereby attest that the foregoing statements and those that I make in any documents that may accompany my accommodations request are true, correct, and complete. I understand and agree that false, incomplete, or inaccurate information may be cause for NABP to delay issuance or invalidate the NABP examination score or results; delay or deny authorization to sit for an NABP examination; delay or deny authorization to other NABP examinations, tests, or assessments, such as the NAPLEX or MPJE; or pursue any other remedies available under law. I hereby attest that I personally completed this request Form and agree to verify Information at any time that I may be requested.

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 patient, who is a candidate for an NABP examination. Please type or print the requested information, unless a signature is required.

Practitioner Name: _____

Professional Title: _____

Professional Training, Credentials, Licensing, and Specialization to Support Relevant 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 the 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 information that I provide pursuant to this Practitioner Statement is true and correct and is provided pursuant to the authorization to release information signed by my patient. I further certify that I have the necessary specialized training to make the diagnosis herein, that I personally examined the candidate named herein, and that I used my professional judgment to render the diagnosis herein and assess the accommodation request. I acknowledge that the school or college of pharmacy at which my patient is enrolled, Board of Pharmacy, or National Association of Boards of Pharmacy® (NABP®) may contact me, pursuant to the candidate's permission to obtain further information if necessary, and that the Board of Pharmacy or NABP may obtain an independent assessment by another professional.

Practitioner's Signature: _____ Date: _____

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PART III: ACADEMIC, INSTITUTION, SCHOOL, OR COLLEGE STATEMENT

The individual named below is requesting testing accommodations for the North American Pharmacist Licensure Examination®, the Multistate Pharmacy Jurisprudence Examination®, and/or the Pharmacy Curriculum Outcomes Assessment®. Please type or print the requested information to complete the Form and provide the signature of an authorized representative of the academic institution, school, or college (School) to provide the data requested in this statement. Please complete this Form and return it and all supporting documentation to the candidate.

I hereby authorize the designated academic institution to provide the requested information regarding the accommodations that the School provided to me:

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 and recommendations from a qualified practitioner who assessed the student and the student's accommodations request. Please list the information and documentation that supported the accommodation approval:

_____

_____

_____

_____

Certification

I hereby certify that I am an authorized representative of the School and that the information provided pursuant to this statement is true, accurate, and complete, and is provided pursuant to the authorization and release signed by the candidate named herein. I understand that the Board of Pharmacy or NABP may contact me or other School representatives to obtain further information if necessary.

Signature of School Representative: _____ Date: _____