Request for Testing Accommodations: NABP's Pharmacy Jurisprudence Examination for Technicians™ (PJET™) Examination

The Request for Testing Accommodations Form (Form) is provided to assist the boards of pharmacy and 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 Parts I and II 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)**

Additional details are available in the *PJET Candidate Application Bulletin* in the Programs section of the NABP website at *www.nabp.pharmacy.*

Submission, Review, and Approval Processes

Please note that during the evaluation process for all NABP examinations, NABP may contact the candidate or practitioner(s) 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, and/or a health care practitioner's statement.

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 your 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 (if applicable). 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.

Validity Periods

Approval of accommodations is valid for one year from the date of notification of approval to the candidate. Candidates must resubmit a new Form and supporting documents if their disability status or requested accommodation(s) change. NABP may require additional documentation or modify formerly approved accommodations.

Request for ADA Testing Accommodations
NABP's Pharmacy Jurisprudence Examination for Technicians (PJET) Examination

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 name(s), including any suffixes.

Name: _____

Address: _____

_____

e-Profile ID Number: _____ Telephone Number: _____

Email Address: _____ Birth Date: _____
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).*

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: _____

Email Address: _____

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 Board of Pharmacy (Board), 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 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 and NABP reserve the right to require additional Information or documentation to support this request for accommodations 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 PJET; 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: _____

Request for ADA Testing Accommodations NABP Examinations

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: _____

State License Number: _____

Professional training, credentials, licensing, and/or specialization to support relevant diagnoses and appropriate recommendation (please attach appropriate written documentation citing credentials):

_____

_____

_____

Office Address: _____

Telephone Number: _____

Patient's Name: _____ Patient's Address: _____

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

Number of Years as a Patient: _____ ICD Code(s): _____

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 Board of Pharmacy or the 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: _____