

Request for Testing Accommodations

NABP Examinations

The Request for Testing Accommodations form (Form) is provided to assist the National Association of Boards of Pharmacy® (NABP®) and/or the board of pharmacy in evaluating a request, for reasonable and appropriate testing accommodations in accordance with the Americans with Disabilities Act (ADA), by individuals with documented disabilities or a medical condition who demonstrate a need for accommodations and request accommodations prior to testing.

Instructions

To request testing accommodations, please download, complete, and submit Parts I and II, and, if applicable, Part III of the fillable Form, including supporting documentation in its entirety as required. Retain a copy for your records. Submit the completed Form and supporting documentation pursuant to the instructions below for the examination you are applying for.

- **Part I:** Candidate Statement
- **Part II:** Practitioner Statement, including practitioner's supporting documentation.
- **Part III (if applicable):** Academic, Institution, School, or College Statement of past accommodations (only applies to candidates who graduated from a United States Accreditation Council for Pharmacy Education-accredited school of pharmacy fewer than three years ago).

Additional details are available in the *North American Pharmacy License Examination®/Multistate Pharmacy Jurisprudence Examination® (NAPLEX®/MPJE®) Candidate Application Bulletin*, the *Foreign Pharmacy Graduate Examination Committee™ (FPGEC®) Candidate Application Bulletin*, the *Pharmacy Jurisprudence Examination for Technicians™ (PJET™) Candidate Application Bulletin* and the Programs section of the NABP website at www.nabp.pharmacy.

Submission Instructions:

NAPLEX/MPJE/PJET 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.

FPGEE Candidates

Download and complete the Form and supporting documentation and email to adarequest@nabp.pharmacy at the time you purchase your FPGEE examination. These requests will be reviewed by NABP. NABP will contact you after the review of your request is completed. ADA testing accommodations will only be granted with the authorization of NABP. Candidates whose requests have been approved must schedule their testing appointment with Pearson VUE.

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/territory, including the provision of state-specific documentation, if any. Your completed Form and supporting 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 must schedule their testing appointment with Pearson VUE.

Validity Periods

Accommodations approval is valid for one year from the date of NABP's notification of approval unless earlier revoked in writing by you. The Form may be considered for any NABP examination occurring within the validity period. You must resubmit a new Form and supporting documents if your disability status or requested accommodation(s) change.

Request for ADA Testing Accommodations NABP Examinations

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 middle initial(s), and last names, including any suffixes.*

NAME:	
DATE OF BIRTH:	
ADDRESS:	
TELEPHONE NUMBER:	
E-PROFILE ID:	
EMAIL:	

For which of the examinations are you requesting accommodation? (Please check all boxes that apply)

- NAPLEX
- MPJE
- FPGEE
- PJET

ACCOMMODATIONS HISTORY

List any accommodations received for previous standardized examinations, such as college, graduate, or professional school admission tests and professional licensure or certificate examinations.

NAME OF EXAM	DATE	ACCOMMODATION(S) RECEIVED

I DID NOT RECEIVE ADA ACCOMMODATIONS IN THE PAST. PLEASE DESCRIBE WHY:

e-Profile ID:

Candidate Name (Last, First):

PLEASE PROVIDE A DETAILED WRITTEN SUMMARY THAT DESCRIBES YOUR DISABILITY, SUPPORT FOR THE REQUESTED ACCOMMODATION(S), TREATING PRACTITIONER'S NAME, AND CURRENT TREATMENT/THERAPY PRESCRIBED OR RECOMMENDED FOR THE DISABILITY (E.E., MEDICATION REGIMEN, PHYSICAL AIDS, ETC).

1. _____

PRACTITIONER NAME: _____

ADDRESS: _____

PHONE NO.: _____

2. _____

PRACTITIONER NAME: _____

ADDRESS: _____

PHONE NO.: _____

3. _____

PRACTITIONER NAME: _____

ADDRESS: _____

PHONE NO.: _____

4. _____

PRACTITIONER NAME: _____

ADDRESS: _____

PHONE NO.: _____

e-Profile ID: _____

Candidate Name (Last, First): _____

e-Profile ID: _____

Candidate Name (Last, First): _____

Authorization, Release, and Attestation (AR&A):

I hereby authorize each treating practitioner listed herein to release to and discuss with the National Association of Boards of Pharmacy® (NABP®) and the Board of Pharmacy (Board) 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 to discuss Information with a treating practitioner, each other, or the school or college I attended. I agree that this AR&A shall be valid for one year, unless earlier revoked in writing by me. I understand that NABP or the Board 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 NABP and the Board 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, 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: _____

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/ CREDENTIALS:	
OFFICE ADDRESS:	
OFFICE PHONE NUMBER:	
OFFICE FAX NUMBER:	
EMAIL ADDRESS:	
STATE OF LICENSURE:	
STATE LICENSE NUMBER:	

PATIENT NAME:	
DATE PATIENT FIRST CONSULTED:	
DATE PATIENT LAST CONSULTED:	
NUMBER OF YEARS AS A PATIENT:	

The following is a list of the NABP Examinations and the time allotment for normal exam time:

- **North American Pharmacist Licensure Examination (NAPLEX)**
6-hour exam composed of 225 questions, includes two (10-minute) breaks
- **Multistate Pharmacy Jurisprudence Examination (MPJE)**
2.5-hour exam composed of 120 computer-based questions, no breaks included
- **Foreign Pharmacy Graduate Equivalency Examination (FPGEE)**
4.5-hour exam composed of 200 questions, includes two (15-minute) breaks
- **Pharmacy Jurisprudence Examination for Technicians (PJET)**
2.5-hour exam composed of 120 questions, no breaks included

e-Profile ID:

Candidate Name (Last, First):

Please list each diagnosis and provide an explanation of the impairment and/or functional limitation necessitating accommodation. ***If additional time is required as accommodation, please provide a specific time allotment.***

DIAGNOSIS 1:	ICD-10:	YEAR DIAGNOSED:
Explain impairment and/or functional limitation that diagnosis has on testing ability and/or accessibility:		
Recommended Accommodation:		
DIAGNOSIS 2:	ICD-10:	YEAR DIAGNOSED:
Explain impairment and/or functional limitation that diagnosis has on testing ability and/or accessibility:		
Recommended Accommodation:		
DIAGNOSIS 3:	ICD-10:	YEAR DIAGNOSED:
Explain impairment and/or functional limitation that diagnosis has on testing ability and/or accessibility:		
Recommended Accommodation:		

Please attach any supporting documentation, including the current treatment for the disability (any medication management or physical aids), any current and applicable test used to support the diagnosis or recommendation for accommodations. If accommodation was not provided to the candidate in the past, please provide a written explanation, on official letterhead, of why accommodation is requested now and why it was 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 recommend the accommodation request. I acknowledge that the National Association of Boards of Pharmacy® (NABP®) or the Board of Pharmacy may contact me, pursuant to the candidate’s permission, to obtain further information if necessary.

Practitioner’s Signature: _____ Date: _____

e-Profile ID: _____

Candidate Name (Last, First): _____

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PART III: ACADEMIC, INSTITUTION, SCHOOL, OR COLLEGE STATEMENT (if applicable)

The individual named below is requesting testing accommodations for the North American Pharmacist Licensure Examination® and/or the Multistate Pharmacy Jurisprudence Examination®. 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.

SCHOOL NAME:	
NAME OF SCHOOL OFFICIAL COMPLETING FORM:	
TITLE:	
ADDRESS:	
PHONE NUMBER:	
EMAIL ADDRESS:	

PLEASE SELECT THE ACCOMMODATION(S) TYPE AND LENGTH OF TIME ACCOMMODATION WAS PROVIDED:

- TIME** (extended time, additional breaks, etc): _____
- PRESENTATION** (large font, reader, etc): _____
- RESPONSE** (verbal, scribe, recorder): _____
- SETTING** (separate room): _____
- OTHER:** _____

The accommodation was: a one-time event OR an ongoing accommodation

(Date Range: _____)

ADDITIONAL NOTES/SUPPORTIVE DOCUMENTS

Please attach any 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 National Association of Boards of Pharmacy® (NABP®) or Board of Pharmacy may contact me or other School representatives to obtain further information if necessary.

Signature of School Representative: _____ Date: _____

e-Profile ID: _____

Candidate Name (Last, First): _____