Application for Disability Accommodation
Pharmacy Licensing Examinations

PART I: Applicant's Statement

Name_____ Social Security Number_____

Address _____

_____

Telephone Number (_____) _____ Birthdate _____

Examination: NAPLEX _____ MPJE _____ State Exam _____ Test Dates _____

Description of disability and how it impacts taking examinations _____

_____

_____

Physician, Therapist, or Other Health Care Practitioner
(List additional practitioners on a separate sheet of paper and attach to this form.)

Name _____

Office Address _____ Phone _____

Length of Time as Patient _____

Type of Accommodation(s) Requested _____

_____

_____

If you have previously been provided with test accommodation(s), please list the provider and describe the accommodation(s).

_____

_____

_____

Release

I authorize the practitioner(s) listed above to release to the Board of Pharmacy or its legal representative any and all information in his or her possession about my disability described above. "Information" means all information in the possession of or derived from providers of health care regarding my medical history, mental or physical condition, or treatment. I agree that this authorization shall be valid until canceled in writing by me.

I understand that the Board of Pharmacy will use the information obtained by this authorization to determine eligibility for a reasonable accommodation with regard to the pharmacist licensure examination by reason of my disability. The Board reserves the right to require additional information or documentation to support this request for accommodation. The Board will not release any information obtained to any person or organization, except to NABP (the test developer), or any government agency that may be involved with my application to take the pharmacist licensure examination.

Under penalties of perjury, I declare that the foregoing statements and those in any accompanying documents or statement are true. I understand that false information may be cause for denial or loss of a license. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time.

Signature _____ Date _____

Subscribed and sworn to before me this _____ day of _____ 20 _____

Notary Public _____

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PART II: Practitioner's Statement

Practitioner Name _____

Professional Title _____

Office Address _____

_____

Telephone Number (_____) _____ State License Number (if applicable) _____

Patient's Name _____

Patient's Address _____

_____

Patient's Social Security Number _____

Date Patient First Consulted _____ Date Patient Last Seen _____

Diagnosis of Disability and Basis for Diagnosis _____

_____

_____

_____

_____

_____

_____

Recommended Accommodation(s) _____

_____

_____

_____

_____

_____

_____

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 individual named above, and that the above diagnosis and assessment of accommodation request is my professional judgment. I understand that the Board of Pharmacy may contact me (with the applicant's permission) to obtain further information if necessary, and that the Board may obtain an independent assessment by another professional.

Practitioner's Signature _____ Date_____