APPLICATION FOR TESTING ACCOMMODATIONS

Please carefully review the Nevada Board of Psychological Examiners Policies for Applicants with Disabilities to ensure that you provide *the required documentation* from a qualified professional.
Submission of incomplete information will delay the processing of your request.

Send your completed form with supporting documentation to the Board office **10 days** prior to the next scheduled Board meeting to:

Nevada Board of Psychological Examiners
4600 Kietzke Lane B116
Reno, NV 89502

Please type or print.

Accommodations are requested for the following examination:

Examination:_____Date: _____

1. Your Name: _____
   Last First Middle Initial
2. Date of Birth: _____
3. Social Security Number (last 4 digits):_____
4. Trainee, Intern, or Psychological Assistant Registration Number (if applicable): #_____
5. Contact Information:

   Daytime Phone: _____

   Cell Phone:_____

   Email Address:_____

   Mailing Address: _____

   _____
6. Nature of Disability:

   ☐ Visual Disability ☐ Physical Disability
   ☐ Hearing Disability ☐ Psychiatric/Mood Disorder
   ☐ Learning Disability ☐ Other:_____
   ☐ Attention Deficit/Hyperactivity Disorder
7. Optional: To support your request, you may attach, in addition to professional documentation, a personal statement describing your disability and its impact on your daily life, educational functioning, and test-taking. If relevant, also describe any current educational or workplace accommodations.
8. How long ago was your disability first professionally diagnosed?

   ☐ less than 1 year ☐ 1–2 years ☐ 2–4 years ☐ 5 or more years

9. What accommodation(s) are you requesting? Accommodation(s) must be appropriate to your disability. *(Check all that apply)*

	Access to locker/Bag lunch/ Beverage/ Medication
	Extra Time: 30 Minutes
	Extra Time: 1 hour
	Extra Time: Time and Half
	Extra Time: Double Time
	Nursing Mother Accommodation
	Separate room
	Separate room & Lip Speaker
	Separate room & May Move
	Separate room & Reader
	Separate Room & Service Animal
	Separate Room & Sign Language Interpreter
	Separate Room and Snacks
	Water Bottle
	Zoom Text (Screen magnification only)

☐ Special physical accommodations at the site
(special lighting, chair, etc.) _____

☐ Extended Breaks (explain; please be specific): _____
_____
_____

☐ Other_____
_____

10. Have you received classroom or test accommodation(s) in the past? Yes No

If yes, please complete Sections A-C below.

A. Standardized Examinations *(Check all that apply)*

Attach documentation showing the accommodations granted when the examination was administered.

☐ SAT Month/Year:_____
Accommodation(s) received: _____

☐ ACT Month/Year:_____
Accommodation(s) received: _____

☐ GRE Month/Year:_____
Accommodation(s) received: _____

☐ Other:_____Month/Year:_____
Accommodation(s) received: _____

B. Graduate Training Program/Internship Yes No

If yes, provide a statement from your program or internship training program explaining the type of accommodations made and date approved. (See form below.)

C. College Yes No

If yes, accommodations received: _____

Authorization:

Under penalties of perjury, I declare that the foregoing statements and those in any required accompanying documentation or statements 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. I certify that the above information is true and accurate. If testing accommodations granted to me include a deviation from the standard testing time schedule, I agree that, from the time I begin the examination until I have completed it, I will not communicate in any way, to the extent possible, with any other individuals taking the examination and I will not communicate in any way with any such individuals about the content of the examination.

This application is valid for a period of one (1) year from the date when first executed by the applicant.

Signature_____ Date _____

If clarification or further information regarding the documentation provided is needed, I authorize the Nevada Board of Psychological Examiners to contact the professional(s) who diagnosed the disability and/or those entities which have provided me test accommodations. I authorize such professional(s) and entities to communicate with the Nevada Board of Psychological Examiners to provide such clarification and/or further information regarding the nature of my disability and the nature of limitations imposed by my disability which affect my ability to perform under standard testing conditions; and the nature of the testing accommodation(s) being proposed and the rationale for those accommodation(s). I further understand that I may be asked to provide additional information about my functional limitation(s) and the requested accommodations and agree to cooperate with reasonable requests for such additional information.

I understand and agree that the information obtained by this authorization will be used solely for the purpose of determining my eligibility for reasonable accommodations in regard to the psychologist licensure process and the nature and extent of the accommodations which are reasonably necessary by reason of my disability. The information obtained by this authorization will not be released or disclosed to any person or organization except the referenced parties, and any other governmental agency that may be involved in acting upon my request for reasonable accommodation in connection with the psychologist licensure process.

I agree that this authorization shall be valid until canceled or revoked in writing by me.

Signature_____ Date _____

If you answered yes to #10 B (Graduate Training Program/Internship):

To be completed by a graduate school or internship official responsible for student/trainee disability services.

Please type or print.

Applicant Name: _____

I,_____, hold the position of_____. I certify
Name *Title*

that_____has officially approved and provided the following test accommodations
Name of Institution

for the above applicant beginning on_____.
Date (Month/Year)

Accommodation(s) provided:

Reason for provision of accommodation(s):

Signature_____ Date _____

Telephone Number _____

(08/02/2019)

State of Nevada Board of Psychological Examiners
APPLICATION FOR DISABILITY ACCOMMODATIONS
PRACTITIONER STATEMENT and DOCUMENTATION

Patient Name: _____

Patient Date of Birth:_____ Patient Social Security Number (last 4 digits): _____

Physician or Licensed Professional:

Name:	
Title:	
State License/ Certification #	
Address:	
Telephone:	

Directions:
To receive accommodations for the Psychology licensing examinations an applicant with a specific disability must submit documentation of their disability that qualifies them for accommodations. The documentation should provide a request for specific accommodations and test results or other evidence of functional impact that support the need for the accommodation.

Practitioners are referred to the Nevada Psychology Board's documentation requirements (to be provided by the applicant) and to the Educational Testing Service (ETS) guidelines. It is important to note that a diagnosis that qualifies for accommodations must rise to the level of significant functional impairment relative to the average person in the general population.

Please answer the following questions and provide supporting documentation. For each question below you have the option to provide and refer to an attached addendum, letter, or evaluation.

1. Please describe your training in assessment, diagnosis or remediation of the referenced disability that qualifies you to make a diagnosis, assess functional impairment and make recommendations for accommodations:

2. Describe the nature and severity of the applicant's disability and how this currently affects the applicant's ability to take the examination, with a focus on the functional impact or limitation resulting from the specific disability:

3. When was this disability first diagnosed and by whom?_____

4. When did you conduct your evaluation of the applicant?_____

5. Describe the methods you used to diagnose and assess the applicant's disability and its impact on their functioning, with particular attention to the affect the disability has on taking exams under standard testing conditions:

6. Describe the results that support your diagnosis and conclusions regarding functional impairment relative to the average person in the general population. Include the applicant's self-reported deficits and objective or collateral evidence of signs, symptoms and functional impact.

7. Do you believe the applicant's motivation level, interview behavior or test-taking behavior was adequate to yield reliable conclusions regarding diagnosis and functional impact? Please explain your answer.

8. If the applicant has no history of testing accommodations, please explain in detail why no accommodations were used in the past and why accommodations are needed now:

9. List your recommended testing accommodations, supporting diagnosis, and test results or history to support the accommodations:

TESTING ACCOMMODATIONS	TEST RESULTS OR HISTORY TO SUPPORT THE NEED FOR THIS ACCOMMODATION	DIAGNOSIS

Certification:

I have been provided with and reviewed a copy of the Nevada Board of Psychological Examiners Policy regarding Requests for Testing Accommodations. I hereby certify that the above information is true and is given pursuant to the authorization to release information by my patient. I declare that the foregoing statements and those in any required accompanying documents or statements are true. I understand that pursuant to Chapter 641 Nevada Revised Statutes, the act of giving false information may be cause for loss of a license or denial of possible licensure. I hereby certify that I personally completed this portion of this application and that I may be asked to verify the above information at any time.

Signature: _____ Date: _____

If applicable, Please Use Physician's Stamp: