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 testing accommodations in accordance with the Americans with Disabilities Act (ADA).

Instructions

To request testing accommodations, please download, complete, and submit Parts I and II 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.

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/FPGEE/PJET Candidates

Upload the completed Forms and supporting documentation in your NABP e-Profile® account during the online application process for examinations. These requests will be reviewed by NABP. The review process may take up to 14 **business days**. Incomplete applications may extend the time for review. NABP will contact you after the review of your request is completed.

Candidates whose accommodations have been approved by NABP will be notified via email and must schedule their testing appointment by calling Pearson VUE customer service (contact information and instructions will be provided in the accommodations approval email).

POST- APPLICATION ADA ACCOMMODATION REQUEST

If you have already applied or scheduled an examination without an ADA accommodations request and would now like to submit a request, contact the exam accommodations team at ADArequest@nabp.pharmacy for more information and for a secure link to submit completed forms and documentation. Approval of accommodations requests submitted outside of the online application process may be delayed.

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 Forms 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 accommodations requests have been approved by NABP must schedule their testing appointment by calling Pearson VUE customer service (contact information and instructions will be provided in the accommodations approval email).

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

e-Profile ID: _____

Candidate Name (Last, First): _____

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 accommodations? (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:

_____
_____
_____
_____

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): _____

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 (collectively," Information") about me or my disability described herein. Information includes all data, information, and documents about me that I possess or that are in the possession of, or derived from, treating practitioners, providers of health care, or the school or college I attended, 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. NABP and the Board reserve the right to require additional Information or documentation to support this request for accommodations or to obtain an independent assessment by a a health care professional or treatment provider. I hereby attest that the information I provide and 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 and inaccurate statements or information are prohibited and may result in one or more actions by NABP including, without limitation, invalidation of NABP examination scores or results, denial or delay in authorization to sit for an NABP examination, notification to treating practitioners, providers, or boards of pharmacy, and NABP may take other actions or seek remedies available under the law. I understand and agree that incomplete statements or information may cause delay in the accommodations and examination processes including, without limitation, in NABP reviewing or approving accommodations, issuance of an authorization to test or to sit for the NABP examination, or release of the NABP examination score or results. 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: _____

e-Profile ID: _____

Candidate Name (Last, First): _____

Request for ADA Testing Accommodations National Association of Boards of Pharmacy® (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 standard 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 an accommodation was not provided to the candidate in the past, please provide a written explanation, on official letterhead, addressing why an accommodation is currently requested but was in the past.

Certification

I hereby certify that the information that I provide pursuant to this Practitioner Statement is complete, true, and correct and is provided pursuant to the authorization to release information signed by my patient who is the examination candidate. 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 and accommodations recommendation set forth in this form. I acknowledge that the candidate authorized release of the diagnosis, recommendation, and related information to the NABP and the Board of Pharmacy and communications between me and NABP or the Board of Pharmacy if necessary.

Practitioner's Signature: _____Date: _____

e-Profile ID: _____

Candidate Name (Last, First): _____