2215 Constitution Ave, NW · Suite 101 · Washington, DC 20037 · Tel. 800-363-8012 · Fax 202-888-1699 · www.ptcb.org

Request for Special Testing Accommodations

The Pharmacy Technician Certification Board (PTCB) complies with the Americans with Disabilities Act of 1990 (ADA). To ensure equal opportunities for all qualified persons, PTCB will make reasonable testing accommodations for certification candidates when appropriate, and consistent with such legal requirements. PTCB will consider requests for special testing accommodations related to any PTCB Certification exams from certification candidates with a documented disability that substantially limits the candidate's sensory, manual, speaking, or other functional skills, including a disability that impairs significantly the candidate's ability to arrive at, read, or otherwise complete, the examination. These accommodations can include additional time to complete the exam or use of approved auxiliary aids.

PTCB requires that each candidate requesting a special testing accommodation complete and submit this form by mail or fax within 30 days of submitting a certification application. A physician or other qualified professional who has made an individualized assessment related to the candidate's disability must provide the required information concerning the disability and the requested accommodation. A qualified professional is a licensed or otherwise properly credentialed individual who possesses expertise in the disability for which an accommodation is sought. The information and any documentation that the candidate provides regarding his/her disability and the need for accommodation(s) will be treated as confidential.

NOTE: Candidates may take breaks at any time during the exam; however, the exam timer will continue to run during breaks. Therefore, extended time should be considered for candidates who require frequent or extended breaks related to their disability.

NOTE: Certain medical or therapeutic equipment and supplies (e.g. eye drops, inhalers/diffusers, diabetic testing equipment) are not allowed in the testing room unless requested as an accommodation. A complete list of items permitted in the testing room is available at www.ptcb.org.

Certification Candidate Information	
Candidate's Name: *(First Middle Initial Last)*	
Candidate ID:	
Home Address:	
City, State, Zip:	
Telephone Number:	
Email Address:	

Candidate Past Accommodations History		
Have you previously received test accommodations during any of the following?	YES	NO
Certification or Licensure Examinations	☐	☐
Vocational Training or Higher Education	☐	☐
Elementary or Secondary School	☐	☐

NOTE: For each "YES" response above, please attach a detailed description of your accommodation history to this form, including but not limited to:

- *The disability related to the accommodation;*
- *The accommodation provided;*
- *The organization providing the accommodation;*
- *The name of the examination for which the accommodation was provided; and*
- *The date the examination and accommodation were provided.*

Also, if you took an exam multiple times but did not receive accommodations for all administrations of the exam, please so indicate.

Qualified Professional Providing Diagnosis	
Professional's Name: *(First Middle Initial Last)*	
Business Address:	
City, State Zip:	
Phone Number:	
Email Address:	
Professional Title: (e.g., Medical Doctor, Licensed Psychologist)	
License Number, and State Issuing License:	
Professional Credential, and Organization Issuing Credential:	

Description of Disability	
Disability Related to the Accommodation Request:	
Date of Most Recent Professional Diagnosis:	
Diagnostic Methods Used:	
Diagnostic Results:	

Requested Accommodation(s) *Please list all accommodations that you are requesting.*		
☐ 1.5 x Exam Time	☐ Magnified Screen Text	☐ Reader
☐ 2.0 x Exam Time	☐ Separate Room	☐ Recorder
☐ Enlarged Font	☐ Other: (please describe)	

Signature of Qualified Professional:

By signing below, I verify that the information provided on this form and in the attached accommodations plan and documentation (if any) is complete and accurate to the best of my knowledge.

Signature of Qualified Professional Date

Signature of Candidate:

By signing below, I verify that the information provided on this form and in the attached accommodations plan and documentation (if any) is complete and accurate to the best of my knowledge. I authorize the release and disclosure of diagnostic information by health care providers, or other professionals having such information, for the purpose of allowing PTCB to make a determination regarding my request for a special testing accommodation. I understand that PTCB will employ reasonable methods to help ensure that the information provided to PTCB regarding my disability and request for accommodation is treated as confidential.

Signature of Candidate Date

Submit the completed form and attachments using the PTCB Help Center at ptcb.org/help.

Completed Form and Any Attachments can also be Mailed or Faxed to:

PTCB
2215 Constitution Ave, NW
Suite 101
Washington, DC 20037
Fax: (202) 888-1699