State of California - Health and Human Services Agency

California Department of Public Health (CDPH)
Nursing Home Administrator Program (NHAP)
MS 3302
P.O. Box 997416
Sacramento, CA 95899-7416
(916) 552-8780 FAX (916) 552-8777
NHAP@cdph.ca.gov

SPECIAL ACCOMMODATION REQUEST FOR EXAMINATION

In compliance with the Americans with Disabilities Act (ADA), Public Law 101-336, the Nursing Home Administrator Program (Program) provides "reasonable accommodations" for applicants with disabilities that may affect their ability to take required examinations. It is the applicant's responsibility to notify the Program of alternative arrangements needed. The Program is not required by the ADA to provide special accommodations if we are unaware of your needs.

The Civil Code, Section 1798.17, requires that this notice be provided when collecting personal or confidential information from individuals. Providing the individual information and identifying information requested on this form is voluntary. Failure to furnish this information to the administering agency, in order to process your application, will result in delays or possible denial of the request. The information requested below and any documentation regarding your disability will be considered strictly confidential and will not be shared with any outside source without your express written permission.

NAME (Last)	*(First)*	*(Middle)*	
ADDRESS (Number and Street Name)	*(City)*	*(State)*	*(Zip Code)*
TELEPHONE NUMBER *(Daytime)* ( ) -	DISABILITY	Is your disability observable? ☐ Yes ☐ No	

REQUIREMENTS FOR SPECIAL ACCOMMODATIONS REQUESTS

You are required to submit documentation from the medical authority or learning institution that rendered a diagnosis. Verification must be submitted to the Program on the letterhead stationery of the authority or specialist and include the following:

- Description of the disability and limitations related to testing
- Recommended accommodation/modification
- Name, title and telephone number of the medical authority or specialist
- Original signature of the medical authority or specialist
- Professional license or certification number of the medical authority or specialist

If you have previously been granted special testing accommodations by an organization that required documentation to verify your disability, the Program may accept a copy of the verification, provided you submit the name, address and telephone number of the medical authority, specialist or learning institution that prepared the documentation. Complete the designated section on the next page of the form.

If your disability is observable and your request does not involve modifying examination procedures, but is limited to wheelchair space, special seating or equipment needs, it is not necessary to obtain professional verification.

Check any special accommodations you require (requests must concur with documentation submitted):

☐ Wheelchair Access

☐ Reader (as accommodation for visual impairment)

☐ Reader (as accommodation for learning impairment)

☐ Extended Testing Time
Additional time requested: ____________________
(Testing time allowed for both exams is hour four (4) hours, forty-five (45) minutes)

☐ Other: ____________________

BOTH PAGES OF THIS FORM MUST BE COMPLETED IN ORDER TO PROCESS YOUR REQUEST

In order to make the necessary arrangements to accommodate your needs, all requests and supporting documentation should be submitted to the Program as soon as possible.

NOTE: The Program normally conducts examinations in hotels or public buildings that are wheelchair accessible. Examinations are administered to applicants seated at table that will accommodate wheelchairs or other walking aids. If you have any questions or need assistance determining whether you may require special accommodations, you may call the Program at (916) 552-8780.

APPLICANTS REQUIRING NEW VERIFICATION

- Return this completed form to the Program with your application
- Contact the necessary medical authority, specialist or organization you wish to verify your disability and request that the documentation listed on Page 1 of this form be sent to:

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P.O. Box 997416
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APPLICANTS WITH *PREVIOUS* VERIFICATION

- Return this completed form to the Program with your application
- Attach a copy of the previous verification of your disability
- Provide the following information for the medical authority or specialist who verified your disability:

NAME (Last)	*(First)*	*(Middle)*	
ADDRESS (Number and Street Name)	*(City)*	*(State)*	*(Zip Code)*
TELEPHONE NUMBER ( ) -		E-MAIL ADDRESS	

The Program will consider all requests on a case-by-case basis. If your request involves modification of examination procedures, it will be necessary for testing staff to speak with you regarding specific arrangements. Therefore, it is **IMPORTANT** that you provide a daytime telephone number. You will receive written confirmation once all requirements have been met.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature	Date

RETURN THIS FORM ONLY IF SPECIAL ACCOMMODATIONS ARE NEEDED

BOTH PAGES OF THIS FORM MUST BE COMPLETED IN ORDER TO PROCESS YOUR REQUEST