Prov, Inc.
9980 S. 300 W.
Suite 200
Sandy, UT 84070
(866) 720-7768

ADA TESTING ACCOMMODATIONS POLICY

Applicants who request testing accommodations pursuant to the Americans with Disabilities Act (ADA) must make the request on the ADA Accommodations Forms. Prov administers the tests in a manner that does not discriminate on the basis of disability against a qualified Applicant. An Applicant who is otherwise eligible to take the Prov Examination may file a request for testing accommodations.
DEFINITIONS

The American with Disabilities Act provides comprehensive civil rights protection for qualified individuals with disabilities. An individual with a disability is a person who: (1) Has a physical impairment or a mental impairment that substantially limits a major life activity (2) Has a record of such an impairment, or (3) is regarded as having such an impairment.

A qualified individual with a disability means an Applicant with disability who, with or without reasonable modification to Rules, Policies or Practices; the removal of architectural, communication or transportation barriers; or the provision of auxiliary aids and services, meets the essential eligibility requirements for licensure for the specific client being tested.

Major life activities include functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. An individual who currently uses illegal drugs is not protected by the ADA when a decision not to provide accommodations is made based upon his/her current illegal use of drugs.

Physical impairment means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems neurological, musculoskeletal, special sense organ, respiratory (including speech organs), cardiovascular, reproductive, digestive genitourinary, hemic and lymphatic, skin and endocrine.

Mental impairment shall mean any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Reasonable accommodations mean an adjustment or modification of the standard testing conditions that ameliorates the impact of the Applicant's disability without doing any of the following (1) Fundamentally altering the nature of the examination such that the ability to determine through the examination whether the Applicant possesses the essential skills and aptitudes that the Board has determined are appropriate to require for (2) Imposing and undue burden on the Board, (3) Compromising the security of the Examination, or (4) Comprising the integrity, the reliability, or the validity of the Examination.

PROCEDURE

A request for testing accommodations shall be on forms prescribed by the Board and shall consist of all of the following. The REQUIRED FORMS are included on the following pages. You may print and copy

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the forms as many times as necessary. NOTE: EVEN IF YOU WERE APPROVED FOR ACCOMODATIONS FOR A PRIOR EXAM, YOU MUST SUBMIT FORM "A" IF YOU WISH TO RECEIVE ACCOMMODATIONS FOR A SUBSEQUENT EXAM.

- **FORM A: Petition for Testing Accommodations –** Must be completed by the Applicant.
- **FORM B: Certificate of Medical/Psychological Authority –** Must be completed by a Physician, psychologist or Professional licensed to diagnose and treat your disability.

  NOTE: Your petition for accommodations **WILL NOT** be considered if **FORM B** is not completed by the authority and returned to Prov by the posted deadline. Please note that the reviewing consultant requires recent testing and/or evaluations to be submitted with Form B—typically within the past 5 years with regard to attention/learning/psychological disabilities and within the past 1 year with regard to physical/visual/hearing disabilities.

- **FORM C: Certificate of Accommodations –** Must be completed by an Official of your school, an Official of a national standardized examination, e.g. ACT; SAT; or LSAT, on which you received testing accommodations, or an Employer who provided you with accommodations.

  NOTE: You **must copy and complete FORM C** as many times as necessary to send to each school, testing entity or workplace where you received accommodations.

- **FORM D: Authorization for Release of Information –** For release of records from the Applicant's medical authorities or for the purpose of determining whether the Applicant is a qualified individual with a disability.

  NOTE: You **MUST copy** and **complete FORM D** as many times as necessary to send to each provider.

The **REQUIRED FORMS** and **associated documentation MUST** be received by Prov at least 3 weeks prior to the desired testing date. Failure to provide all documentation by the deadline may result in you not being considered for the accommodations requested.

MAIL or EMAIL ALL FORMS, DOCUMENTATION, AND CORRESPONDENCE TO:

Lourdes Stalnaker
Prov, Inc.
5200 NW 43rd Street
Suite 102-167
Gainesville, FL 32606
lourdess@provexam.com

If you have any questions about Prov's Testing Accommodations Policy, contact Lourdes Stalnaker at (866) 720-7768, Ext. 113.

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FORM A: PETITION FOR TESTING ACCOMMODATIONS

To be completed by the Applicant. Please type or legibly print.

First Name _____ Last Name _____ Social Security Number _____

Street Address _____

City _____ State _____ ZIP _____

( ) _____ Date of exam you are seeking accommodations (MM/DD/YY) _____

Telephone

1. Describe the physical or mental impairment that is the basis for your request for testing accommodations and explain the impact of this impairment on your ability to take the Prov Examination under standard testing conditions. **Be as specific as possible.**

   _____

   _____

   _____

   _____

2. Provide the date on which you became disabled: _____
3. List the names, professional titles, addresses, and telephone numbers of medical and psychological authorities with whom you have sought assessment and/or treatment for your physical or mental impairment, and include the dates of assessment and/or treatment for each medical or psychological authority. The names listed should be the providers who will be providing a **Certificate of Medical or Psychological Authority.**

Name and Title	Address	Phone Number	Dates of Assessment/Treatment

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4. Describe, in detail, any accommodations you have received for your physical or mental impairment in academic, testing or employment settings. (Provide a **Certificate of Accommodations** from each employer and/or educational institution.)

_____

_____

_____

_____

5. State the testing accommodations you request and explain how the testing accommodation relates to your physical or mental impairment. **(Be as specific as possible.)**

_____

_____

_____

_____

TO BE COMPLETED BY APPLICANT:

I swear or affirm that all the information on this form is true and correct to the best of my knowledge, and I understand that it may be reviewed by a physician or other licensed professional.

_____ _____

Applicant Signature **Date**

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FORM B: CERTIFICATE OF MEDICAL/PSYCHOLOGICAL AUTHORITY

To be completed by Physician, Psychologist, or Professional licensed to diagnose and treat Applicant's impairment. Please type or legibly print. **NOTE TO APPLICANT:** Your Petition for Accommodations **WILL NOT** be considered if **Form B** is not completed by a certified authority and returned to Prov by the posted deadline.

Applicant's Information

First Name _____ Last Name _____ Social Security Number _____

Street Address _____

City _____ State _____ ZIP _____

Authority's Information

First Name _____ Last Name _____ Title _____

Medical Institution/Company _____

Street Address _____

City _____ State _____ ZIP _____

( ) _____ Email Address _____

Telephone

1. Describe your professional qualifications (terminal degree, clinical specialty, licensure, etc.) that enables you to act in the capacity of medical or psychological authority on the Applicant's physical or mental impairment. A recent copy of your curriculum vitae must be attached.

   _____

   _____

   _____

   _____

2. State the date(s) on which you have examined the Applicant:

   _____

   _____

   _____

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3. Describe the nature and severity of the Applicant's physical or mental impairment and discuss its effect on the ability of the Applicant to complete the Examination under standard administration procedures. The exam may consist of one, two, three or four hour exams.

4. List the complete ICD (International Classification of Diseases), diagnosis of the physical impairment or the complete multi axial DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) diagnosis of mental impairment. Include all relevant severity and course specifics.

5. List the studies and/or procedures used to diagnose the physical or mental impairment and attach a copy of all pertinent medical or psychological records, including results of laboratory studies, diagnostic tests, and clinical procedures used to determine presence and severity of the impairment. In the case of psychological and psycho educational testing, please attach all raw data and psychological reports pertinent to impairment.

6. State the testing accommodations you recommend for the Applicant and explain how the testing accommodations relate to the Applicant's physical or mental impairment. If your recommendations for testing accommodations include an extension of the customary examination time, describe your rationale for the amount of time recommended.

TO BE COMPLETED BY THE AUTHORITY:

I certify that all the information is true and correct to the best of my knowledge and belief.

Authority's Signature **Date**

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FORM C: CERTIFICATE OF PREVIOUS ACCOMMODATIONS

To be completed by the appropriate school, employment or testing official regarding the Applicant named below. Please type or legibly print. **NOTICE TO SCHOOL, EMPLOYMENT OR TESTING OFFICIAL:** Attach a copy of any documentation that was used in making a decision regarding accommodations for this Applicant. **NOTE TO APPLICANT:** This form is optional. Your Petition for Accommodations **CAN** be considered without **Form C**.

Applicant's Information

First Name _____ Last Name _____ Social Security Number _____

Street Address _____

City _____ State _____ ZIP _____

Provider's Information

First Name _____ Last Name _____ Title _____

Educational Institution/Company _____

Street Address _____

City _____ State _____ ZIP _____

( ) _____ Email Address _____

Telephone

1. Name the course of study and the dates in which the Applicant was enrolled at your educational institution (or name the Applicant's position and dates of employment).

_____

_____

_____

_____

2. If the Applicant received accommodations, state the nature of the physical or mental impairment of the Applicant that served as a basis for granting accommodations.

_____

_____

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_____

3. Specifically describe the accommodations granted to the Applicant.

_____

_____

_____

_____

TO BE COMPLETED BY THE AUTHORITY:

I certify that all the information is true and correct to the best of my knowledge and belief.

_____ _____

Provider's Signature **Date**

Prov, Inc.
9980 S. 300 W.
Suite 200
Sandy, UT 84070
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FORM D: AUTHORIZATION FOR RELEASE OF INFORMATION

To be completed by Applicant. Please type or legibly print. **NOTE TO APPLICANT:** You **MUST** copy and complete **FORM D** as many times as necessary to send to each provider.

Authorization to Release and Exchange Information between

Prov, Inc.
5200 NW 43rd Street
Suite 102-167
Gainesville, FL 32606

AND

_____
Authority from Form B or Provider from Form C

_____
Address

_____ _____ _____
City State ZIP

( ) _____
Telephone Email Address or Fax Number

REGARDING

_____ _____ _____
First Name Last Name Social Security Number

By my signature below, I authorize the above parties to release and exchange information for the sole purpose of determining testing accommodations. All necessary information may be released, including medical and psychological records, treatment plans, histories and progress notes, admission and discharge summaries, laboratory results, psychological and psychiatric reports, court reports and school records, employment records, psychological, neurological and psycho educational test data. I understand that this authorization will remain in effect for 90 days from the date of signature. I understand that I may withdraw this consent at any time upon written notice. Recipients of this information are forbidden to re-disclose this information to parties not named above.

_____ _____
Applicant Signature **Date**

_____ _____
Witness Signature **Date**