In compliance with the Americans with Disabilities Act (ADA), IJCAHPO® makes reasonable testing accommodations for candidates with professionally diagnosed “disabilities”. If you have a documented disability, you may request special testing accommodations by completing this form. Both Section A (Candidate Request for Special Accommodations for Testing) and Section B (Documentation of Disability-Related Needs) must be completed. The form should be submitted with your examination application to: IJCAHPO, 2025 Woodlane Dr., St. Paul, MN 55125. If you have questions regarding special accommodations, please contact IJCAHPO’s Certification Department.

The information you provide, and any documentation submitted regarding your disability and special testing accommodation, will be held in the strictest confidence.

Section A – Candidate Request for Special Accommodations for Testing

Note: This section is to be completed by the applicant.

Name: ____________________________________________  ______________________  ______________________  ______________________

Address: ________________________________________________

City: __________________ State: __________ Zip Code: __________ Country: __________________

Telephone: ______________________ E-mail: _________________

Exam for which you are applying: □ COA  □ COT  □ COMT  □ Ophthalmic Surgical Assisting  □ CCOA

Have you taken this exam previously? □ Yes  □ No

If yes, were you provided with special accommodations previously? □ Yes  □ No

Requested Accommodation: __________________________________________

_______________________________________________________________________

_______________________________________________________________________

Comments: ____________________________________________

_______________________________________________________________________

_______________________________________________________________________

By my signature below, I attest that the above statements and those in any accompanying documents or statements are true. I understand that supplying false information may be cause for denial or revocation of certification.

_______________________________________________________________________    ______________________

Signature  Date

SECTION B (ON BACK) MUST BE COMPLETED.
Section B – Documentation of Disability-Related Needs

Consent for Disclosure of Information (to be completed by the applicant)

I, _________________________________________________ (printed name of applicant), authorize and request the healthcare professional identified below to release information related to my disability and the appropriate accommodation to the Joint Commission on Allied Health Personnel in Ophthalmology, Inc.®

Signature ___________________________________________________________________________ Date ___________________________________________________________________________

Professional Documentation (to be completed by a healthcare provider who has provided care to the applicant)

I have known _________________________________________________ (printed name of applicant) since __________/________/________ in my capacity as a ___________________________________________________.

The applicant discussed with me the nature of the test to be administered. It is my professional opinion that because of the disability described below, the applicant should be provided the accommodations requested below.

Brief Description of Disability: ___________________________________________________________
___________________________________________________________________________________

Requested Accommodation: _______________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Are you licensed/certified in a specialty that allows you to diagnose the disability? □ Yes □ No

If you are licensed/certified, please indicate your license/certification number:

License/certification number ____________________________________________________________ State/Province ___________________________________________________________

If you are not licensed or certified, please indicate the credentials that allow you to diagnose the disability:

________________________________________________________

Name:

First Middle Last Credential

Address:

City: __________ State: ______ Zip Code: __________ Country: __________

Telephone: ______________________________

Signature ___________________________________________________________________________ Date ___________________________________________________________________________