Request *for* Special Accommodations for Testing

IJCAHPO
INTERNATIONAL JOINT COMMISSION ON ALLIED HEALTH PERSONNEL IN OPHTHALMOLOGY®

Please type or print clearly.

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: _____
First **Middle** **Last**

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 _____.
Month Day Year

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