NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

NOTICE OF INTENT TO ACCESS JURISPRUDENCE EXAMINATION FOR PURPOSES OF OBTAINING A COMPACT PRIVILEGE IN NEBRASKA
Fill out application and mail or e-mail to the address on the left.

Department of Health & Human Services
Division of Public Health – Licensure Unit
P.O. Box 94986
Lincoln NE 68509-4986
dhhs.rehaboffice@nebraska.gov

Legal Name	Last:	First:	Middle:
Maiden Name:		Other names you are known as (AKA):	
Date of Birth (Month/Day/Year):		Age:	
SSN#:			
Phone #:	Fax #:	E-Mail Address:	
Have you already registered and paid your NE LAW (Jurisprudence) Examination fee to FSBPT?		☐ Yes	☐ No
Do you have a disability that requires special accommodations for taking examinations?		☐ Yes	☐ No
If yes, an Accommodation Request Form (Attachment B) must be completed and submitted with your application. If no, do not submit the Accommodation Request Form (Attachment B) with your application.			
Name of Physical Therapy College or University:			
College or University Address:			
Physical Therapy Degree Awarded:			
Date Degree Awarded (month/day/year):			
Home State Where You Hold an Unencumbered License:			

ATTACHMENT B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health
Licensure Unit
ATTN: Physical Therapy
P.O. Box 94986
Lincoln, Nebraska 68509-4986

Special Accommodations Request Form

Section I – Applicant Information

Applicant Name	**Last**	**First**	**Middle**
ADDRESS	**Street/PO/Route:**		
	City:	**State:**	**Zip:**
Home Phone #:	**Alternate Phone #:**	**Email Address:**	
Date of Birth: _____/_____/_____ **Month/ Day / Year**	**Gender:** _____☐ Male _____☐ Female		

Section II – Information about Your Disability and Requested Accommodations

Describe the nature of your disability? ***Please indicate the specific diagnosis.***

_____
_____
_____
_____

When was your disability first diagnosed? _____

How does your disability affect your daily life? _____
_____
_____
_____
_____

How does your disability affect your ability to take the examination? _____
_____
_____
_____

What accommodations are you requesting during the examination?

☐ Additional Time – Time and a half
☐ Additional Time – Double Time
☐ Zoom Text (software that enlarges the print on the computer screen)
☐ Screen magnifier
☐ Reader
☐ Individual who enters the examinee's responses
☐ Separate Room
☐ Other (Non-Standard) – Please Describe

_____

_____

What accommodations have you received in the past for the following exams?

National Physical Therapy Exam _____

PT/PTA School Exams _____

Undergraduate College Exams _____

Standardized Exams (e.g., SAT, GRE, etc.) _____

Section III - Documentation Requirements

A comprehensive and current report (no more than three years old) from a professional qualified for evaluating your disability must accompany this request form. The report must include the following:

- Name, title, credentials and area of specialization of the professional making the diagnosis and accommodation recommendation.
- A diagnosis of the disability pursuant to the International Statistical Classification of Diseases and Related Health Problems (ICD), the Diagnostic and Statistical Manual of Mental Disorders (DSM IV: revised) or other applicable and recognized professional standard with copies of all evaluations and reported scores from professionally recognized diagnostic tests, where applicable.
- Recommendation for specific accommodations.
- Rationale for requesting specific accommodations.

Section IV – Candidate Affirmation

My signature on this form affirms that the information I have provided on this request is true and accurate. I have truthfully represented my disability and the impact it has on my daily life and computerized examinations.

_____ _____

Applicant Signature Date

ATTACHMENT B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health
Licensure Unit
P.O. Box 94986
Lincoln, Nebraska 68509-4986
ATTN: Physical Therapy

Professional Documentation of Disability Form

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist, etc.) to certify that your disabling condition requires the requested test accommodation.

Section I – Applicant Information

Applicant Name	**Last**	**First**	**Middle**
ADDRESS	**Street/PO/Route:**		
	City:	**State:**	**Zip:**
Date of Birth: _____/_____/_____ **Month / Day / Year**		**SSN:**	

Exam Type: ☐ Physical Therapist (PT) Exam ☐ Physical Therapist Assistant (PTA) Exam

Section II – About the Exam

The examination for which this candidate is requesting special accommodations consists of objective multiple choice questions which are administered by computer at a testing center. Minimal computer skills are required.

Standard testing conditions:

Exam	Number of Questions	Time Allowed	Scheduled Break	Unscheduled Breaks
PT	250 (delivered in 5 sections of 50 questions each)	5 hours	15 minute break after Section 2	Breaks can be taken after sections 1, 3, and 4; however, the exam timer will continue to elapse
PTA	200 (delivered in 4 sections of 50 questions each)	4 hours	15 minute break after Section 2	Breaks can be taken after sections 1 and 3; however, the exam timer will continue to elapse

Section III – Professional Contact and Background Information

Name: _____ Title:_____

License Number (if applicable): _____ Expiration Date: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Please describe your credentials and experience which qualify you to make this diagnosis and recommendations for testing. You may also attach your CV to show this information.

_____

_____

Section IV – Disability and Requested Accommodations

1. Describe the diagnosed disability and date of diagnosis. Attach all written evaluations supporting the diagnosis, including the scores and interpretive data for all administered diagnostic tests.

_____

_____

_____

2. Date of your last consultation with the candidate_____

3. Please describe: (1) the nature, history, and extent of the disability; (2) how it limits one or more of the candidate's major life activities; (3) if the disability will change in any way over time. In case of a learning disability, include specifics as to the type of disability (e.g., visual or auditory reception or perception, processing, memory, comprehension, verbal or written expression, etc.)

_____

_____

_____

_____

4. What effect does the disability have on the candidate's ability to perform on the test as described above?

_____

_____

_____

_____

5. What are your specific recommendations for accommodations for this candidate? **Please include an explanation of why these accommodations are required.**

- ❑ Additional Time – Time and a half
- ❑ Additional Time – Double Time
- ❑ Zoom Text (software that enlarges the print on the computer screen)
- ❑ Screen magnifier
- ❑ Reader
- ❑ Individual who enters the examinee's responses
- ❑ Separate Room
- ❑ Other (Non-Standard) – Please Describe

_____

_____

I certify that I have the necessary specialized training to make the above diagnosis, that I personally examined the candidate named above, and that the diagnosis and assessment of accommodations requested are based on my professional judgment. I understand that the candidate has authorized me to provide the information on this form, and to provide further information if necessary.

_____ _____

Signature Date

_____

Name (Printed)

ATTACHMENT B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health
Licensure Unit
P.O. Box 94986
Lincoln, Nebraska 68509-4986
ATTN: Physical Therapy

The following sections are to be completed by the person responsible for disability services at your Physical Therapist/Physical Therapist Assistant Program.

School ADA Accommodation History Form

Section I – Applicant Information

Applicant Name	**Last**	**First**	**Middle**
ADDRESS	**Street/PO/Route:**		
	City:	**State:**	**Zip:**
Date of Birth: _____/_____/_____ **Month / Day / Year**		**SSN:** _____	**Phone:** _____

Section II – School Contact Information

Name: _____Title:_____

School Name and Address: _____

_____

Phone: _____ Fax: _____ Email:_____

Section III – Disability and Accommodations History

1. Specify the type of disability for which the candidate received accommodations (e.g., visual, learning/cognitive, psychological, etc.)

_____
_____
_____

2. What accommodations were provided to this candidate while he or she was a student at your institution? (Check all that apply.)

- ❑ Additional Time – Time and a half
- ❑ Additional Time – Double Time
- ❑ Zoom Text (software that enlarges the print on the computer screen)
- ❑ Screen magnifier
- ❑ Reader
- ❑ Individual who enters the examinee's responses
- ❑ Separate Room
- ❑ Other (Non-Standard) – Please Describe

_____

_____

I certify that the information provided by me on this form is true and correct to the best of my knowledge. I understand that the candidate has authorized me to provide the information on this form, and to provide further information if necessary.

_____ _____

Signature Date

_____

Name (Printed)