



STATE OF NEBRASKA
Department of Health and Human Services
Division of Public Health – Licensure Unit
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CONFIDENTIAL INFORMATION

This form may be completed online and mailed to the address listed above.

ACCOMMODATION REQUEST FORM
MENTAL HEALTH PRACTITIONER EXAMINATION

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered a confidential record and will not be shared with any outside source without your express written permission, unless release is ordered by a court of competent jurisdiction, or otherwise authorized by law.

Form with fields: Applicant Name (First, MI, Last), ADDRESS (Street/PO/Route, City, State, Zip), Name of Examination, Telephone No, Date of Examination, Specify Disability

(Check all that apply)

- Accessible Testing Site
Braille
Large print
Tape
Reader as accommodation for visual impairment
Scribe/amanuensis as accommodation for visual or motor impairment
Reader as accommodation for learning disability
Scribe/amanuensis as accommodation for learning disability
Sign Language Interpreter
Extended Time
Time-and-a-half
Double time
More than double time (specify):
Separate testing area
Use of computer or other adaptive equipment (specify):
Other (specify):

Comments:

Signed: Date:

Some accommodation requests may require additional documentation (see reverse side)

## DOCUMENTATION OF DISABILITY RELATED NEEDS

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) to certify that your disabling condition requires the requested test accommodation.

IF YOU HAVE EXISTING DOCUMENTATION OF HAVING THE SAME OR SIMILAR ACCOMMODATION PROVIDED TO YOU IN ANOTHER TEST SITUATION, YOU MAY SUBMIT SUCH DOCUMENTATION INSTEAD OF HAVING THIS PORTION OF THE FORM COMPLETED.

I have known \_\_\_\_\_ since \_\_\_\_\_  
(test applicant) (date)

in my capacity as a \_\_\_\_\_  
(professional title)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following: (check all that apply)

- Taped test
- Large print test
- Reader
- Scribe/amanuensis
- Extended time:
  - Time-and-a-half
  - Double time
  - More than double time (please justify): \_\_\_\_\_
- Separate testing area
- Use of computer or other adaptive equipment (please specify): \_\_\_\_\_
- Other (please specify): \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

License # (if applicable): \_\_\_\_\_