D&S DIVERSIFIED TECHNOLOGIES LLP
PO BOX #418, FINDLAY, OH 45839-0418
TOLL FREE 877-851-2355 – LOCAL 419-420-1605 - FAX 419-422-8328 – www.hdmaster.com

PROVIDING STNA TESTING SOLUTIONS THROUGHOUT OHIO

REQUEST FOR ADA ACCOMMODATION— UPDATED MAY 2013

Form 1101 OH and form 1402 OH must accompany this form.

Applicant: Complete this form ONLY if you have a documented disability.

In compliance with the Americans with Disabilities Act (ADA), the STNA Testing Program provides reasonable accommodations for applicants with disabilities that may affect their ability to take the Nurse Aide Competency Examination (NACE) examination. It is your responsibility to notify the STNA testing program of the needed alternative arrangements. If you have a disability for which you wish to request an accommodation, please provide the following information and return this form as well as all other required documentation to D&S DT with your application. You may attach additional pages if necessary. Accommodations will *NOT* be provided at the examination site unless this form and all other documentation are received with your application. In order to grant testing accommodations, the STNA testing staff must share information concerning your request with the RN and their testing team who will observe your performance on the manual skill and/or knowledge portion of the examination. The information requested below and any documentation regarding your disability is considered strictly confidential and will be shared only with the RN Test Observer, necessary test team members and Ohio State Agencies. Please sign your name on this form to indicate your permission for D&S DT to share information about your disability with the RN Observer, necessary test team members, and State Agencies.

Name:_____Social Security #:_____-_____-_____
Last First

Address:_____
Street City State Zip

Phone:_____Work Phone:_____Date of Birth:_____

I plan on testing at the following location:_____Site #_____

___Reader Marker ___ Additional Time___ Large Print___ Other please explain:_____
_____

Describe your disability and how this substantially limits one or more of your major life activities:

_____
_____
_____

Explain the nature and extent of your disability and how it impairs your ability to take the STNA examination:

_____
_____
_____

Describe the accommodation you are requesting:

_____
_____

Describe the accommodations granted to you during your Nursing Assistant Training Program:

Written Test:_____

Skill Test:_____

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****Please remember that if special equipment is required that the candidate is responsible to bring on testing day and checking in with the State Tester****

REQUIRED DOCUMENTATION FOR ADA ACCOMMODATION REQUESTS:

THE FOLLOWING INFORMATION MUST ACCOMPANY THIS FORM:

1. **You are required to submit documentation from the *Health Care Provider* or *Learning Specialist* who rendered a diagnosis.**

2. **Verification must be submitted to D&S DT on the letterhead stationary of the *Health Care Provider* or *Learning Specialist* and MUST include the following:**

   (1) Specific description of the disability and limitations related to testing.

   (2) Specific recommended accommodation.

   (3) **Name, title and telephone number of the *Health Care Provider* or *Learning Specialist.***

   (4) Original signature of the *Health Care Provider* or *Learning Specialist.*

REQUIRED DOCUMENTATION MUST BE ATTACHED WITH THIS APPLICATION

Your signature below indicates that you understand this application and the documentation you included and give permission to D&S Diversified Technologies, their Test Observers, Written Test Proctors, and Actors, and appropriate Ohio State Agencies to be informed of accommodations requested. The information requested and documentation regarding your disability is considered strictly confidential and will be shared only with the parties listed above. Your signature below indicates that you understand this and you give permission to D&S Diversified Technologies to share this information as described.

Applicants Signature: _____Date:_____

Signature of Parent or Legal Guardian if Minor:_____Date:_____

NOTE: IN ORDER TO MAKE THE NECESSARY ARRANGEMENTS TO ACCOMMODATE YOUR NEEDS, ALL REQUESTS AND SUPPORTING DOCUMENTATION MUST BE SENT TO D&S DT WITH YOUR APPLICATION. D&S DT MUST APPROVE and arrange for ALL ACCOMMODATIONS PRIOR TO YOUR TEST DATE.

D&S DT will consider all requests on a case-by-case basis. It will be necessary for testing staff to speak and correspond with you regarding specific arrangements. Therefore, it is *IMPORTANT* that you provide a current address and daytime telephone number and keep the D&S DT informed if these change. You will receive written confirmation of any approved or denied accommodations. You *MUST* notify the testing staff if you are unable to take the examination on the date for which you are scheduled.

Type of documentation attached:

_____IEP _____504 Other:_____

_____Letter from physician identifying diagnosis _____Letter from Learning Specialist which rendered diagnosis

For office use only:
ADA approved by:_____Date:_____Other:_____