



Request for Accommodation form
Applicant Information and Service Provider Information

Notice of Disability – (leading to accommodation during testing)

Complete this form if you are requesting accommodations during testing

Medically Recognized Disability: If you are notifying the NCSCB OF A DISABILITY AS RECOGNIZED by the Americans with Disability Act (ADA) please enclose the specific form and your medical doctor’s notations and signature with this application. This will initiate a review and proper accommodation of your disability.

Full Name of Applicant:				
	Last	First	M. I.	
Address				
	Street Address			
	Street Address			
	City	State	Zip	

I hereby acknowledge that personal information and medical records pertaining to my disability will be released to the National Cable Splicing Certification Board (NCSCB) for the purposes of providing accommodation during the NCSCB exams that are appropriate to my disability.
 Signature: _____ on this _____ day of _____ 2006

Information Below is for Medical Provider or Individual Assessment Provider

The applicant referenced above is requesting that the National Cable Splicing Certification Board (NCSCB) provide reasonable accommodation relating to a particular disability listed below. This information will be used to enable the applicant to take the NCSCB exams with appropriate accommodations for his disability.

Applicants desiring accommodation must provide current documentation of the disability from a medical provider or individual assessment provider able to assess the applicant and the particular disability. The applicant is requesting that you provide such documentation.

The medical provider or individual assessment provider completing this form should provide an accurate analysis of the disability and a recommended method of accommodating the disability. Supporting documentation should be attached that would explain the nature of the disability and how the recommended accommodation pertains to the disability.

All documentation should include the following information:

Nature of disability, Record of appointments/previous consultations by you for the applicant and the disability

List all tests/exams used to determine the disability, Expected results of accommodation plan developed

Provide detailed accommodation plan

Name of Medical or individual Assessment Provider Information:				
	Last	First		
Address				
	State and State License Number			
	Street Address			
	City	State	Zip	
Phone	Fax			

I have examined the above named applicant and recommend the attached accommodation plan.
 Signature: _____ on this _____ day of _____ 2006

Press back button to return to NCSCB