

# D&S Diversified Technologies

dba Headmaster

PO Box 6609, Helena, MT 59604-6609

Toll Free 800-383-8664 – Local 406-442-8656 · Fax 406-442-3357 - www.hdmaster.com

**PROVIDING CNA TESTING SOLUTIONS THROUGHOUT IDAHO**

## REQUEST FOR ADA ACCOMMODATION

Form 1101 ID and form 1402 ID 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 CNA 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 CNA 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 Headmaster 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 at the time of submission of the application. In order to grant testing accommodations, the CNA staff must share information concerning your request with the Written Test Proctor who will proctor your written CNA examination. The information requested below and any documentation regarding your disability is considered strictly confidential and will be shared only with the Written Test Proctor and the Idaho Department of Health. Please sign your name on this form to indicate your permission for Headmaster to share information about your disability with the Written Test Proctor and the Idaho Department of Health.

NAME: \_\_\_\_\_  
(Last) (First) (Middle)

ADDRESS: \_\_\_\_\_

Daytime Telephone Number: ( ) \_\_\_\_\_

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

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

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Describe the accommodation you are requesting:

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## **REQUIRED DOCUMENTATION FOR ACCOMMODATION REQUESTS:**

You are required to submit documentation from the *Health Care Provider* or *Learning Specialist* who rendered a diagnosis. Verification must be submitted to Headmaster on the letterhead stationery 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*.**

If you were granted testing accommodations for examinations during your basic Nursing Assistant Training Program, you should submit a letter from the primary instructor of the program verifying these accommodations.

See Form 1404-Supplemental (attached) for additional costs associated with granted accommodations.

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

Headmaster 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 staff informed if these change. You will receive written confirmation of your approved accommodations. You ***MUST*** notify the testing staff if you are unable to take the examination on the date for which you are scheduled.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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## HEADMASTER TESTING AND REGISTRY ACCOMMODATION APPLICATION Supplemental

- This APPLICATION MUST ACCOMPANY FORM 1101 ID and 1402 ID
- Applications must be received in the Helena office 10 working days prior to requested test date.
- Accommodations are granted in accordance with the Americans with Disabilities Act
- Typically accommodations would be used during training in order to be approved for testing.

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Maiden/Former

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

### Special Accommodation Requested:

\_\_\_\_ Reader Marker      \_\_\_\_ Additional Testing Time      \_\_\_\_ Large Print

\_\_\_\_ Other, please explain \_\_\_\_\_

Include an additional \$50.00 per individual to help offset the additional cost the accommodation will impose as an undue hardship on the normal testing operation. If no accommodation is granted the \$50 will be refunded. (See form 1402 ID)

OFFICIAL USE ONLY: SITE # _____ PACKET# _____ TEST DATE _____ SCHEDULER: _____
TEST EVALUATOR _____ DATE ACCOMMODATION Granted: _____
OTHER: _____ DATE ACCOMMODATION Denied: _____