



D&S Diversified Technologies LLP
Headmaster LLP

HEADMASTER LLP
 P.O. Box 6609, Helena, MT 59604-6609
 800-393-8664 – Fax: 406-442-3357
 www.hdmaster.com

*Innovative, quality technology solutions
 throughout the United States since 1985.*

Describe the accommodations you are requesting:

You must submit documentation from a *health care provider or learning specialist* who rendered a disability or diagnosis. Documentation must include the following:

1. Description of the disability and limitations related to testing
2. Recommended accommodation(s)
3. Name, title, telephone number and signature of the Health Care Provider, Learning Specialist or Instructor

OR

If you were granted ADA testing accommodations during your Nursing Assistant Training Program, you must have your primary instructor sign this form verifying any accommodations granted.

HEADMASTER will consider all requests on a case-by-case basis. It may 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 HEADMASTER staff informed if these changes.

In order to provide testing accommodations, HEADMASTER must share the information you provide with the Montana Department of Health, Nurse Aide Registry and the Test Event Staff. The information requested above and any documentation regarding your disability is considered strictly confidential and will be shared only with parties on a need-to-know basis. Your signature below indicates that you understand this and you give permission to HEADMASTER staff to do so.

Applicant Signature: _____ **Date:** ____/____/____

I certify that I was the above Candidate's *primary instructor*, and that I provided the accommodations detailed herein during said Candidate's Nursing Assistant Training Program.

Primary Instructor Printed Name: _____ Contact #: _____

Primary Instructor Signature: _____ Date: ____/____/____

*Primary Instructor Printed Name: _____ Contact #: _____

*Primary Instructor Signature: _____ Date: ____/____/____

*Second signature necessary only if primary instructor was different for classroom and clinical training.