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.

OKLAHOMA MEDICATION AIDE
REQUEST FOR ADA ACCOMMODATION – FORM 1404KM

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

In compliance with the Americans with Disabilities Act (ADA), the Medication Aide Testing Program provides reasonable accommodations for applicants with disabilities that may affect their ability to take the Medication Aide Competency Examination (MACE). It is your responsibility to notify the Medication Aide 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 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 is received with your application and the requested accommodation is granted prior to testing. In order to grant testing accommodations, the Medication Aide testing staff must share information concerning your request with the RN/KPT who will observe administer your knowledge exam. The information requested below and any documentation regarding your disability is considered strictly confidential and will be shared only with the RN/KTP Test Observer and Oklahoma State Agencies. Please sign your name on this form to indicate your permission for HEADMASTER to share information about your disability with the RN/KTP Observer and State Agencies.

*********** (Any specialized equipment required must be provided by the candidate)***********

Name:____ Social Security#:__________-__________-______________
Last First

Address:____
Street City State Zip

Phone:______________________Work Phone: ____________________Date of Birth:_______________________

Requested Accommodation: ____

____

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 Medication Aide examination:
Describe the accommodation you are requesting:

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____

____

Describe the accommodations granted to you during your Medication Aide Training Program:

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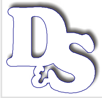
____

 D&S Diversified Technologies 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.*

REQUIRED DOCUMENTATION FOR ADA ACCOMMODATION REQUESTS:

You are **required** to submit documentation from the *Health Care Provider* or *Learning Specialist* who rendered an ADA diagnosis. Verification must be submitted to HEADMASTER 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.***

If you were granted testing accommodations during your Medication Aide Training Program, you must complete this form with your Primary Instructor verifying any accommodations granted. The Primary Instructor **must** sign this form verifying any provided training accommodations. Your signature below indicates that you understand this application and the documentation you included and give permission to HEADMASTER staff, the designated RN Test Observers, Knowledge Test Proctors and appropriate Oklahoma 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 on a need to know basis. Your signature below indicates that you understand this and you give permission to HEADMASTER, LLP to share this information as described.

Applicant's Signature: ____Date:_________________________

I certify that I was the above candidate's Primary Instructor, and that I provided the accommodations detailed herein during the candidate's Medication Aide Training Program.

Primary Instructor Signature:____________________________Phone:________________Date:_____________

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.

All requests will be considered 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 HEADMASTER informed of any changes. 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.

SIGNATURE: ___________________________________TITLE:______________________DATE: _____________

ADDITIONAL NOTES: