PENNSYLVANIA STATE BOARD OF NURSING
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HARRISBURG, PA 17105-8411

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www.dos.state.pa.us/nurse
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REQUEST FOR ACCOMMODATIONS

Review instructions before completion:

1. Submit the completed *Request for Accommodations* Form located on the Board website.
2. The form must be completed by a licensed physician, psychologist, certified registered nurse practitioner, or physician assistant (if the accommodation is not based upon a physical condition).
3. The accommodations requested must be **specific** (if extended time, specify the time, for example, 2 hours, separate room etc.)
4. A copy of the evaluation and testing results, both within the last 5 years, must accompany the accommodation request.
5. Additional documentation may be requested and is the responsibility of the applicant to obtain and submit.
6. On reexam, applicants will receive the same accommodations as initially granted unless requesting a change in the accommodation originally provided. Any modifications to the original request requires submission of a new accommodation request and documentation.

SECTION 1: COMPLETED BY APPLICANT REQUESTING ACCOMMODATIONS FOR THE LICENSURE EXAM.

Last Name: _____

First Name: _____

Social Security Number: _____

SECTION 2: COMPLETED BY THE NURSING EDUCATION PROGRAM DIRECTOR.

Nursing Education Program Name: _____

Were modifications provided while individual enrolled in the nursing education program? Yes _____ No _____

Describe modifications provided: _____

_____

Director Signature and Title: _____ Date: _____

Telephone number: _____

REQUEST FOR ACCOMMODATIONS
(Exam Applicants Only)

Applicant Name: _____ **Date of Birth:** _____

SECTION 3: This form must be completed by a licensed physician, psychologist, certified registered nurse practitioner, or physician assistant.

Specific diagnosis(es): _____

_____

DSM Code(s) and Title(s): _____

Treatment/medication history: _____

_____

Date of initial diagnosis(es) and treatment: _____

Date of most recent evaluation: _____
(**ATTACH** copy- the evaluation must be within the last 5 years)

Current treatment/medication status: _____

_____

SPECIFIC accommodation(s) requested (Read above instructions 1-6): _____

_____

Rationale: _____

_____

Professional's name (type or print legibly): _____

Professional's signature: _____ Date: _____

State of Licensure: _____ License Number: _____

Specialty certification/qualifications: _____