OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
DIVISION OF HEALTH PROFESSIONS
121 South Fruit Street, Suite 102
Concord, N.H. 03301-2412

PETER DANLES
Executive Director

SHERI WALSH
Division Director

Board of Nursing  603-271-2323
Nursing Assistant  603-271-6282
Fax  603-271-6605
www.oplc.nh.gov/nursing

Request for Nursing Assistant Competency Testing Accommodations
under the Americans with Disabilities Act

Please print

Last Name: ___________________________ First Name: ___________________________

Other Names Used: __________________________________________________________________________

Address: __________________________________________________________________________________

Home Phone: ______________________ Email Address: ______________________________________

Please submit this form, completed, along with the following information:

1. _____ A personal statement indicating the specific modifications / accommodations being requested and
   the rationale for the request.

2. _____ Documentation from the nursing assistant program coordinator supporting the request for
   accommodation. This must include a history of the disability and any past accommodation granted the
   candidate during the clinical and theoretical portions of the nursing assistant program and a description
   of its impact on the individual functioning.

3. _____ Results of appropriate diagnostic testing by a qualified professional with expertise in the area(s)
   of the diagnosed disability including identification of the specific standardized and professionally
   recognized test/assessment given (e.g. Woodcock-Johnson, Weschler Adult Intelligence Scale). A
   professionally recognized diagnosis must be included in the documentation.

4. _____ Interpretation of the scores resulting from the diagnostic testing by a qualified professional with
   recommendations for testing accommodations with a stated rationale as to why the requested
   accommodation is necessary and appropriate for the diagnosed disability.

Following receipt of the materials indicated above, the ADA Committee of the Board will review the
information submitted and make a determination regarding the request for accommodations. You will be
notified of the Committee’s decision and the decision will be submitted to the Nursing Assistant Competency
Testing Company.

For office use only:

_____ Accommodations Approved  _____ Accommodations Not Approved

Additional Information Needed: _________________________________________________________________

__________________________________________________________________________________________

Signature: __________________________ Date: ____________________________

TDD Access: Relay NH 1-800-735-2964