

D&S DIVERSIFIED TECHNOLOGIES LLP

PO Box #418, FINDLAY, OH 45839-0418

TOLL FREE 877-851-2355 – LOCAL 419-420-1605 - FAX 419-422-8328 - www.hdmaster.com

PROVIDING STNA TESTING SOLUTIONS THROUGHOUT OHIO

REQUEST FOR ADA ACCOMMODATION— UPDATED September 2018

Form 1101 OH and form 1402 OH 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 STNA Testing Program provides reasonable accommodations for applicants with disabilities that may affect their ability to take the Nurse Aide Competency Examination (NACE). It is your responsibility to notify the STNA 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 D&S DT 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 with your application. In order to grant testing accommodations, the STNA testing staff must share information concerning your request with the RN and their testing team who will observe your performance on the manual skill and/or knowledge portion of the examination. The information requested below and any documentation regarding your disability is considered strictly confidential and will be shared only with the RN Test Observer, necessary test team members and Ohio State Agencies. Please sign your name on this form to indicate your permission for D&S DT to share information about your disability with the RN Observer, necessary test team members, and State Agencies.

Name: _____ Social Security #: _____ - _____ - _____
Last First

Address: _____
Street City State Zip

Phone: _____ Work Phone: _____ Date of Birth: _____

I plan on testing at the following location: _____ Site # _____

Reader Marker Additional Time Large Print Other please explain: _____

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 STNA examination:

Describe the accommodation you are requesting:

Describe the accommodations granted to you during your Nursing Assistant Training Program:

Written Test: _____

Skill Test: _____

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****Please remember that if special equipment is required that the candidate is responsible to bring on testing day and checking in with the State Tester****

REQUIRED DOCUMENTATION FOR ADA ACCOMMODATION REQUESTS:

THE FOLLOWING INFORMATION MUST ACCOMPANY THIS FORM:

- 1. You are required to submit documentation from the *Health Care Provider* or *Learning Specialist* who rendered a diagnosis.**
- 2. Verification must be submitted to D&S DT 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*.**

REQUIRED DOCUMENTATION MUST BE ATTACHED WITH THIS APPLICATION

Your signature below indicates that you understand this application and the documentation you included and give permission to D&S Diversified Technologies, their Test Observers, Written Test Proctors, and Actors, and appropriate Ohio 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. Your signature below indicates that you understand this and you give permission to D&S Diversified Technologies to share this information as described.

Applicants Signature: _____ **Date:** _____

Signature of Parent or Legal Guardian if Minor: _____ **Date:** _____

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

D&S DT 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 D&S DT informed if these change. 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.

Type of documentation attached:

____ IEP _____ 504 Other: _____

____ Letter from physician identifying diagnosis _____ Letter from Learning Specialist which rendered diagnosis

For office use only:

ADA approved by: _____ Date: _____ Other: _____

Training program email notification sent _____ Date by: _____