SOUTH DAKOTA REQUEST FOR ACCOMMODATION

South Dakota Health Care Association
804 N. Western Avenue --Sioux Falls, SD 57104
Phone# 605-339-2071
luannseverson@sdhca.org
Testing Services Provided by: HEADMASTER, LLP

Request for Accommodation

Print this form, complete it, and email or fax it to South Dakota Health Care Association at 605-339-1354. Thank you.

In compliance with the Americans with Disabilities Act, the South Dakota Health Care Association and the HEADMASTER Nurse Aide Testing Program provide accommodations for applicants with disabilities that may affect his or her ability to take the Nurse Aide Competency Exam.

If you are a Candidate with a disability or limitation for which you wish to request an accommodation, please complete both pages of this form and attach the required documentation. This will assist HEADMASTER in determining appropriate accommodations for you. These documents must be submitted to the South Dakota Health Care Association. ***Accommodations cannot be provided at the test unless this form and all other documentation are received and approved 5 business days PRIOR to your exam date. If the request is not received within this time frame, the test event will need to be rescheduled.***

Name:

_____

Last First Middle Maiden/Former

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

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 test:

_____

_____

_____

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

_____

_____

_____

_____

Describe the accommodations you are requesting:

_____

_____

_____

_____

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REQUIRED DOCUMENTATION FOR ADA ACCOMMODATION REQUESTS:

An applicant requesting special testing accommodation must provide the following to SDHCA.

- Documentation including recent (within the last four years, unless the disability is documented by the professional as stable and permanent) reports, test results, evaluations and assessments of the candidate's need for accommodations due to a disability (physical or mental impairment) that substantially limits one or more major life activities. Major life activities include walking, seeing, hearing, speaking, breathing, learning, thinking, working, caring for one's self and performing manual tasks. Mental impairment includes any mental or psychological disorder, such as organic brain syndrome, emotional or mental illness and specific learning disabilities, which are protected under the Americans with Disabilities Act (ADA). Documentation by a qualified professional with expertise in the areas of the diagnosed disability which supports the request for accommodations, including results of appropriate diagnostic testing, must be submitted.

DOCUMENTATION MUST INCLUDE:

⇒ A history of the disability and any past accommodation(s) granted to the candidate, as well as a description of its impact on the individual's functioning.

⇒ Identification of the specific standardized and professionally recognized test/assessments given (e.g., Woodcock-Johnson, Weschler Adult Intelligence Scale).

⇒ The scores resulting from testing, interpretation of the scores and evaluations.

⇒ Recommendations for testing accommodations with a stated rationale as to why the requested accommodations are necessary and appropriate for the diagnosed disability.

⇒ Contact information including name, qualifications, phone of the professional evaluator recommending the accommodation.

If you were provided accommodation in the nursing assistant program, the instructor must sign the request for accommodations form verifying that the accommodation requested was provided by the program. 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, their RN Test Observers, Written Test Proctors, and Actors, and appropriate South Dakota 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 to share this information as described.

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 Signature:_____ Date: _____/_____/_____

Primary Instructor Phone Number: (_____) _____-_____

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

Primary Instructor Phone Number: (_____) _____-_____

This candidate will be scheduled to test with the following Headmaster Certified Test Observer:

Test Observer Name: _____ Phone Number: (_____) _____-_____
(Please print)

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