

# **ADA Accommodations**

## **Nurse Aid Exam**

### **Certification**

---

Contains:

1. Submission of complete Testing Accommodation Request packet requirement
2. Timelines (deadlines for testing accommodation requests)
3. Testing Accommodation Request Form
4. Professional Evaluation Form

Central Louisiana Technical Community College (CLTCC) provides equal access and opportunity for all qualified persons without regard to disability in the participation of all college programs and activities pursuant to the Americans with Disabilities Act of 1990 (ADA) and other related federal and state law. This includes providing test-taking candidates with accommodations on the Nurse Aide Certification Exam to accurately assess skill and aptitude, without undue influence from a functional limitation associated with the candidate's disability.

Test-takers are asked to carefully review the packet and to complete the packet to the best of their knowledge. A complete testing accommodation packet will include:

- Testing Accommodation Request form
- Documentation of disability or the Professional Evaluation Form

**Incomplete accommodation request packets will not be considered.**

The testing accommodation packet will be sent to the CLTCC Testing Administration Staff at:  
Email address  
Physical address

Timeframe for Processing:

The testing accommodation packet should be received 30 days prior to the certification exam date to ensure the request can be reviewed and approved, as well as coordinating and implementing the testing accommodations. All requests for accommodations will be confidential. Test-takers will not be assessed any additional charges for necessary accommodations.

To ensure your testing accommodation packet can be fully processed, please note the following:

1. Test-takers are responsible for providing disability documentation from a qualified professional. This means a professional who has comprehensive training and experience in both evaluating and diagnosing the disability or condition.
2. Testing candidates can provide existing disability documentation from the qualified professional. Documentation should include the diagnosis of the disability, limitations of the disability (ies), and recommendations for testing accommodations.
3. Test-takers also have the option to have the qualified professional complete the Professional Evaluation Form (see page 4).
4. Activities of daily living (e.g., eating, ambulating, toileting, etc.) will not be approved as accommodations.
5. Additional disability documentation/ verification may be requested in some situations, such as when there is a need for further clarification around the nature of the disability or requested accommodations.

## Testing Accommodation Request Form

Name of Testing Candidate: \_\_\_\_\_

Test-Taker ID: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Alternative Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Exam Site Requested: \_\_\_\_\_

Disability (ies): \_\_\_\_\_

Type of Accommodation Requested:

Extended time for testing (50% increase; time plus one-half) \_\_\_\_\_

Reduced distraction testing environment \_\_\_\_\_

Enlarged font for printed information \_\_\_\_\_

Recorder of answers \_\_\_\_\_

Sign Language Interpreter (ASL) \_\_\_\_\_

Additional Comments/ Needs: \_\_\_\_\_

- I authorize the CLTCC Testing Administrating Staff to review the attached forms and coordinate the requested testing accommodations.
- I consent to the qualified professional who certified my disability(ies) to speak with the CLTCC Testing Administration Staff about the functional limitations of my disability (ies), onset and history, and any other pertinent information required for the implementation of the testing accommodations.
- If further disability documentation/ verification is required, the testing accommodation request packet will not be processed until that information is provided to the CLTCC Testing Administration Staff.

Testing Candidate Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Professional Evaluation Form

Testing Candidate Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

This individual is requesting testing accommodations/ modifications on the Certified Nurse Aide Examination. In order to consider this request, as well as to ensure the provision of reasonable and appropriate accommodations, we require a Qualified Professional provide documentation of the candidate's disabilities. A qualified professional has comprehensive training and experience in evaluation and diagnosing, and *who is not a family member of the testing candidate*.

The purpose of the testing accommodation is to allow the testing candidate to demonstrate knowledge and proficiencies while adjusting for functional limitations associated with the disabilities. Testing accommodations provide access, but do not offer an unfair advantage. The documentation provided must include information that diagnoses the disability/ condition, describes the functional limitations in a testing setting, and indicates the severity and longevity of the disabilities for the purpose of determining testing accommodations.

To facilitate the gathering of such critical information, please respond to the following and return to Central Louisiana Technical Community College Testing Administration Staff.

1. Diagnosis (DSM/ ICD Code): \_\_\_\_\_

2. Date of Diagnosis: \_\_\_\_\_ Date of Last Contact with Candidate: \_\_\_\_\_

3. Describe the student's functional limitations in a testing setting. \_\_\_\_\_

\_\_\_\_\_

4. Please indicate the RECOMMENDATIONS you have regarding necessary and appropriate testing accommodations/ modifications.

\_\_\_\_\_

\_\_\_\_\_

Qualified Professional's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name & Title: \_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Licensure Number: \_\_\_\_\_ State of Licensure: \_\_\_\_\_

Board Certification: \_\_\_\_\_