American Board of Electrodiagnostic Medicine

DISABILITY ACCOMMODATION REQUEST FORM

The ABEM supports the intent of the Americans with Disabilities Act (ADA). The Board will make a reasonable effort to provide qualified Board candidates who have documented disabilities the necessary auxiliary aids and services that do not fundamentally alter the measurement of the skills or knowledge the Board's program is intended to test or result in an undue burden (28CFR § 36-309 [b] [3]).

All information you provide regarding your disability and your need for accommodation will be considered strictly confidential and will not be shared with any outside source without your expressed written permission. You are invited to call the Board office for further instructions before returning the application.

Please Type or Print

1. ***Accommodations are requested for the following examination:***
   - ☐ **Physician** - Initial Certification
   - ☐ **Technologist** - CNCT examination
   - ☐ **Physician** - Maintenance of Certification

2. ***Name:***

   _____ _____ _____
   Last *First* *Middle Initial*

3. ***Address:***

   _____ _____
   Street *Phone Number*

   _____ _____ _____
   City *State/Province/Country* *Postal Code*

4. ***Nature of Disability:***
   - ☐ Hearing
   - ☐ Psychiatric
   - ☐ Learning
   - ☐ Visual
   - ☐ Physical
   - ☐ Other _____
     Please specify

5. Please describe your disability and list the name and telephone number of an expert who can document your disability. (This person may or may not be contacted. The Board reserves the right to verify your disability):

   _____ _____
   Name *Phone* *Number*

   Description:

   _____

   _____

   _____

6. Please indicate the most recent testing setting in which accommodations were provided, if any:

_____

_____

_____

7. Please check all disability-related accommodations that you have received in the past:

☐ Brailled materials	☐ Reader	☐ Use of computer/other adaptive equipment
☐ Taped audio materials	☐ Scribe	☐ Separate testing area
☐ Taped video materials	☐ Sign language interpreter	☐ Extended testing time
☐ Large print	☐ Other _____	

Please specify

8. What accommodations are you requesting? *Accommodations must be appropriate to the disability*.

_____

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_____

I certify that the above information is true and accurate. If clarification of further information regarding the documentation provided is needed, I authorize the ABEM to contact the professional(s) who diagnosed the disability and/or those entities which have provided me test accommodations. I authorize such professional(s) and entities to communicate with the ABEM in this regard and to provide the ABEM with such clarification and/or further information.

Signature _____ ***Date*** _____