

## **National Board Dental/Dental Hygiene Examinations Testing Accommodation Request**

The Joint Commission on National Dental Examinations (JCNDE) provides reasonable and appropriate accommodations in accordance with the Americans with Disabilities Act for individuals with documented disabilities who demonstrate a need for accommodation.

The Americans with Disabilities Act defines a person with a disability as an individual with a physical or mental impairment that substantially limits one or more major life activities.

Problems such as English as a second language, slow reading without an identified underlying cognitive deficit, or failure to achieve a desired outcome are not learning disabilities and are not applicable to the Americans with Disabilities Act.

At the discretion of the JCNDE, testing accommodations may be provided to an examinee with a disability to offer equal access to testing. Once approved for testing accommodations all subsequent testing will be approved for testing accommodations. Examinee's must request testing accommodations with each application, but will not be required to submit additional documentation.

### **Request for Testing Accommodations and Appropriate Documentation**

The following information will assist you in submitting the appropriate documentation to support the testing accommodation request. The documentation will validate that the individual qualifies for accommodations under the Americans with Disabilities Act.

To verify the disability and its severity, the JCNDE requires a complete evaluation of the examinee as well as the completed and signed Testing Accommodation Request form. A licensed professional appropriately qualified for evaluating the disability must conduct the evaluation.

If you have a documented disability in accordance with the Americans with Disabilities Act and require testing accommodations, you must:

1. Notify the JCNDE that you are requesting testing accommodations at the time you submit your National Board application and prior to scheduling a testing appointment.
2. Submit the Testing Accommodation Request Form found at [www.ada.org](http://www.ada.org) or attached here to, signed, and dated, describing the disability and the need for accommodations. Accommodations should align with the identified functional limitation so that the adjustment to the testing procedure is applicable to the identified impairment. A functional limitation is defined as the behavioral manifestation of the disability that impedes the individual's ability to function.
3. Submit a current evaluation report (within the past five years) from the appropriate licensed professional. The document should include the professional's credentials, address, and telephone number. The report must indicate the examinee's name, date of birth, and date of evaluation. The report should include:
  - a. The specific diagnostic procedures or tests administered. Diagnostic methods used should be appropriate to the disability and in alignment with current professional protocol. Examples of test administered may include, but are not limited to, the Wechsler Adult

Intelligence Test, Wechsler Memory Scale, Wechsler Individual Achievement Test, Test of Attention and Executive Functions, Test of Memory, Test of Language, Tests of Visual Perception/Construction, and Tests of Personality/Mood.

- b. The results of the diagnostic procedures and/or tests and a comprehensive interpretation of the results.
  - c. The specific diagnosis of the disability, with an accompanying description of the examinee's limitations due to the disability.
  - d. A summary of the complete evaluation with recommendations for the specific accommodations and how they will reduce the impact of identified functional limitation.
4. Submit documentation of any previous accommodations provided by educational institutions or other testing agencies. If no prior accommodations were provided, the licensed professional should include a detailed explanation as to why no accommodations were given in the past and why accommodations are needed now.

### **Unacceptable Forms of Documentation**

Please do not submit the following documents. The JCNDE will not accept them.

- 1) Handwritten letters from licensed professionals
- 2) Handwritten patient records or notes from patient charts
- 3) Diagnoses on prescription pads
- 4) Self-evaluations found on the Internet or in any print publication
- 5) Research articles
- 6) Original evaluation/diagnostic documents; submit copies of the original documents.
- 7) Previous correspondence from the JCNDE; JCNDE maintains copies of all correspondence.
- 8) Correspondence from educational institutions or testing agencies not directly addressed to the JCNDE.

**National Board Dental/Dental Hygiene Examinations  
Testing Accommodation Request**

Please return this signed form and supportive documentation by U.S. mail to the Joint Commission on National Dental Examinations: Testing Accommodation Request at 211 East Chicago Avenue, Suite 600, Chicago, Illinois 60611-2637. Upon receipt, the JCNDE will review your request and notify you in writing of the decision.

| <b>Personal Information</b> |                          |           |
|-----------------------------|--------------------------|-----------|
| First Name                  | Middle Initial           | Last Name |
| Street Address              |                          |           |
| City                        | Daytime Telephone Number |           |
| State                       | Social Security #        |           |
| Zip Code                    |                          |           |

| <b>Accommodation History</b>   |                                  |
|--|----------------------------------|
| Indicate any previous accommodations you received and the corresponding dates. |                                  |
| <b>Standardized Examination</b>  | <b>Educational Institution</b>   |
| Name of Test:  | Name of Educational Institution: |
| Date(s):   | Date(s):                         |
| Specific accommodation received:   | Specific accommodation received: |
| Other:   | Other:                           |

| <b>Nature of Disability</b>   |                          |
|---|--------------------------|
| Circle or highlight the disabling condition and indicate the year of diagnosis. |                          |
| <b>Disability</b>   | <b>Year of Diagnosis</b> |
| <b>Language Impairments</b>   |                          |
| Expressive Language Disorder  |                          |
| Receptive Expressive Language Disorder  |                          |
| Receptive Language Disorder   |                          |
|   |                          |
| <b>Learning Impairments</b>   |                          |
| Mathematics Disability  |                          |
| Reading Disability  |                          |
| Writing Disability  |                          |
|   |                          |
| <b>Medical Impairments</b>  |                          |
| Diabetes  |                          |
| Epilepsy  |                          |
| Other   |                          |
|   |                          |
| <b>Mental Health Impairments</b>  |                          |
| Attention Deficit Disorder  |                          |
| Attention Deficit Hyperactivity Disorder  |                          |
| General Anxiety Disorder  |                          |
|   |                          |
| <b>Sensory Impairments</b>  |                          |
| Hearing Disability  |                          |
| Visual Disability   |                          |
|   |                          |
| <b>Other</b>  |                          |
|   |                          |
|   |                          |
|   |                          |

**Requested Accommodation**

Indicate the specific accommodation you are requesting; accommodation must be applicable to the disability.

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**Authorization**

I, the undersigned, certify that the information I have provided is correct. I give permission to the Joint Commission on National Dental Examinations to contact the licensed professional (who diagnosed my disability) and/or the educational institution (that granted me previous testing accommodation) for additional information or clarification as needed. I authorize such professionals and educational institutions to provide the JCNDE with such clarification and/or further information as needed.

Candidate's Signature: \_\_\_\_\_

Date: \_\_\_\_\_