Prov, Inc.
200 West Civic Center Dr., Suite 160, Sandy, UT 84070
Provexam.com | (866) 720-7768

AMERICANS WITH DISABILITIES ACT

ADA Testing Accommodations Policy

Applicants who request testing accommodations pursuant to the Americans with Disabilities Act (ADA) must make the request on the ADA Accommodations Forms. Prov administers the tests in a manner that does not discriminate on the basis of disability against a qualified Applicant. An Applicant who is otherwise eligible to take the Prov Examination may file a request for testing accommodations.

✓ Definitions

The Americans with Disabilities Act provides comprehensive civil rights protection for qualified individuals with disabilities. An individual with a disability is a person who: (1) has a physical impairment or a mental impairment that substantially limits a major life activity, (2) has a record of such an impairment, or (3) is regarded as having such an impairment.

A qualified individual with a disability means an Applicant with a disability who, with or without reasonable modification to Rules, Policies, or Practices; the removal of architectural, communication, or transportation barriers; or the provision of auxiliary aids and services, meets the essential eligibility requirements for licensure for the specific client being tested.

Major life activities include functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. An individual who currently uses illegal drugs is not protected by the ADA when a decision not to provide accommodations is made based upon his/her current illegal use of drugs.

Physical impairment means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organ, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin and endocrine.

Mental impairment shall mean any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Reasonable accommodations mean an adjustment or modification of the standard testing conditions that ameliorates the impact of the Applicant's disability without doing any of the following: (1) fundamentally altering the nature of the examination such that the ability to determine through the examination whether the Applicant possesses the essential skills and aptitudes that the Board has determined are appropriate to require; (2) imposing an undue burden on the Board; (3) compromising the security of the Examination; or (4) compromising the integrity, the reliability, or the validity of the Examination.

✓ Procedure

A request for testing accommodations shall be on forms prescribed by the Board and shall consist of all of the following. The required forms are included on the following pages — you may print and copy the forms as many times as necessary.

> Even if you were approved for accommodations for a prior exam, you must submit Form A if you wish to receive accommodations for a subsequent exam.

FORM A **Petition for Testing Accommodations**
Must be completed by the Applicant.

FORM B **Certificate of Medical / Psychological Authority**
Must be completed by a physician, psychologist, or professional licensed to diagnose and treat your disability.
NOTE: Your petition WILL NOT be considered if Form B is not completed by the authority and returned by the posted deadline. The reviewing consultant requires recent testing and/or evaluations — typically within the past 5 years for attention/learning/psychological disabilities and within the past 1 year for physical/visual/hearing disabilities.

FORM C **Certificate of Accommodations**
Must be completed by an official of your school, a national standardized examination (e.g., ACT, SAT, or LSAT) on which you received accommodations, or an employer who provided accommodations.
NOTE: Copy and complete Form C as many times as necessary to send to each school, testing entity, or workplace.

FORM D **Authorization for Release of Information**
For release of records from the Applicant's medical authorities or to determine whether the Applicant is a qualified individual with a disability.
NOTE: Copy and complete Form D as many times as necessary to send to each provider.

All required forms and associated documentation must be received by Prov at least 3 weeks prior to the desired testing date. Failure to provide all documentation by the deadline may result in your request not being considered.

MAIL OR EMAIL ALL FORMS, DOCUMENTATION & CORRESPONDENCE TO
Lourdes Stalnaker — Prov, Inc.
200 West Civic Center Dr., Suite 160, Sandy, UT 84070
lourdess@provexam.com | (866) 720-7768, Ext. 4

If you have any questions about Prov's Testing Accommodations Policy, contact Lourdes Stalnaker at the number above.

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FORM A • COMPLETED BY THE APPLICANT

Petition for Testing Accommodations

✓ Applicant Information

FIRST NAME

LAST NAME

STREET ADDRESS

CITY

STATE

ZIP

TELEPHONE

DATE OF EXAM SEEKING ACCOMMODATIONS (MM/DD/YY)

1. Describe the physical or mental impairment that is the basis for your request for testing accommodations and explain the impact of this impairment on your ability to take the Prov Examination under standard testing conditions. Be as specific as possible.

2. Provide the date on which you became disabled.

DATE BECAME DISABLED

3. List the names, professional titles, addresses, and telephone numbers of the medical and psychological authorities with whom you have sought assessment and/or treatment, including the dates for each. These should be the providers who will be providing a Certificate of Medical or Psychological Authority.

NAME & TITLE	ADDRESS	PHONE	TREATMENT DATES

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FORM A • CONTINUED

Petition for Testing Accommodations

4 **Describe, in detail, any accommodations you have received for your physical or mental impairment in academic, testing, or employment settings. Provide a Certificate of Accommodations from each employer and/or educational institution.**

5 **State the testing accommodations you request and explain how the accommodation relates to your physical or mental impairment (be as specific as possible). Accommodations will be considered for implementation within written exam conditions, unless otherwise specified by providers, such as for practical exams.**

To be completed by the Applicant

I swear or affirm that all information on this form is true and correct to the best of my knowledge, and I understand that it may be reviewed by a physician or other licensed professional.

APPLICANT SIGNATURE

DATE

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FORM B • COMPLETED BY THE AUTHORITY

Certificate of Medical / Psychological Authority

To be completed by a physician, psychologist, or professional licensed to diagnose and treat the Applicant's impairment. Please type or legibly print.

NOTE TO APPLICANT: Your Petition for Accommodations WILL NOT be considered if Form B is not completed by a certified authority and returned to Prov by the posted deadline.

APPLICANT'S INFORMATION

FIRST NAME

LAST NAME

OPTIONAL ID NUMBER

STREET ADDRESS

CITY

STATE

ZIP

TELEPHONE

DATE OF EXAM SEEKING ACCOMMODATIONS (MM/DD/YY)

AUTHORITY'S INFORMATION

FIRST NAME

LAST NAME

TITLE

MEDICAL INSTITUTION / COMPANY

STREET ADDRESS

CITY

STATE

ZIP

TELEPHONE

EMAIL ADDRESS

1 Describe your professional qualifications (terminal degree, clinical specialty, licensure, etc.) that enable you to act in the capacity of medical or psychological authority on the Applicant's impairment.

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FORM B • CONTINUED

Certificate of Medical / Psychological Authority

2. State the date(s) on which you have examined the Applicant.

3. Describe the nature and severity of the Applicant's impairment and discuss its effect on the ability of the Applicant to complete the Examination under standard testing center procedures. The exam may be multiple hours. If accommodations are needed for practical/skills testing, please specify.

4. List the complete ICD diagnosis of the physical impairment or the complete multi-axial DSM-5-TR diagnosis of mental impairment. Include all relevant severity and course specifics.

5. List the studies and/or procedures used to diagnose the impairment and attach all pertinent medical or psychological records (laboratory studies, diagnostic tests, clinical procedures). For psychological and psycho-educational testing, attach all raw data and reports. Specify how findings provide specific evidence for a need for accommodation not provided in typical testing conditions.

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FORM B • CONTINUED

Certificate of Medical / Psychological Authority

6 **State the testing accommodations you recommend for the Applicant and explain how they relate to the Applicant's impairment. If your recommendations include an extension of the customary examination time, describe your rationale for the amount of time recommended, a specific recommended time, and support for that requested time.**

To be completed by the Authority

I certify that all the information is true and correct to the best of my knowledge and belief.

AUTHORITY SIGNATURE	DATE

Prov✓

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FORM C • COMPLETED BY SCHOOL, EMPLOYER, OR TESTING OFFICIAL

Certificate of Previous Accommodations

To be completed by the appropriate school, employment, or testing official regarding the Applicant named below. Please type or legibly print. Attach a copy of any documentation used in making a decision regarding accommodations for this Applicant.

> NOTE TO APPLICANT: This form is optional. Your Petition for Accommodations CAN be considered without Form C.

APPLICANT'S INFORMATION

FIRST NAME

LAST NAME

OPTIONAL ID

STREET ADDRESS

CITY

STATE

ZIP

AUTHORITY'S INFORMATION

FIRST NAME

LAST NAME

TITLE

EDUCATIONAL INSTITUTION / COMPANY

STREET ADDRESS

CITY

STATE

ZIP

TELEPHONE

EMAIL ADDRESS

1. **Name the course of study and the dates in which the Applicant was enrolled at your educational institution (or name the Applicant's position and dates of employment).**

2. **If the Applicant received accommodations, state the nature of the impairment that served as a basis for granting accommodations.**

FORM C • CONTINUED

Certificate of Previous Accommodations

3 Specifically describe the accommodations granted to the Applicant.

To be completed by the Authority

I certify that all the information is true and correct to the best of my knowledge and belief.

AUTHORITY SIGNATURE

DATE

FORM D • COMPLETED BY THE APPLICANT

Authorization for Release of Information

Please type or legibly print. You must copy and complete Form D as many times as necessary to send to each provider. This authorizes the release and exchange of information between the parties below.

PARTY ONE

Lourdes Stalnaker — Prov, Inc.
200 West Civic Center Dr., Suite 160, Sandy, UT 84070
lourdess@provexam.com | (866) 720-7768, Ext. 4

AND

PARTY TWO — AUTHORITY FROM FORM B OR PROVIDER FROM FORM C

NAME

STREET ADDRESS

CITY

STATE

ZIP

TELEPHONE

EMAIL ADDRESS OR FAX NUMBER

REGARDING

FIRST NAME

LAST NAME

OPTIONAL ID

By my signature below, I authorize the above parties to release and exchange information for the sole purpose of determining testing accommodations. All necessary information may be released, including medical and psychological records, treatment plans, histories and progress notes, admission and discharge summaries, laboratory results, psychological and psychiatric reports, court reports and school records, employment records, and psychological, neurological and psycho-educational test data. This authorization will remain in effect for 90 days from the date of signature. I may withdraw this consent at any time upon written notice. Recipients of this information are forbidden to re-disclose it to parties not named above.

APPLICANT SIGNATURE

DATE

WITNESS SIGNATURE

DATE