Endocrine Certification in Neck Ultrasound (ECNU) Program

Special Testing Accommodations (STA) for Candidates with Disabilities Request

SECTION 1: To be completed by ECNU Candidate

First Name: _____Middle: _____Last:_____

Address (do not use a PO Box): _____

City: _____State: _____

Zip/Postal Code: _____ Country: _____

E-mail: _____ Daytime Phone: _____

Are you repeating the ACE Comprehensive Certification Examination (CCE)? ❑ Yes ❑ No

If yes, did you receive special accommodations before? ❑ Yes ❑ No ❑ N/A

Please describe your disability:

What accommodation(s) are you requesting from ACE?

I understand that ACE will use the information obtained by this authorization to determine eligibility for a reasonable accommodation in regard to the ACE Comprehensive Certification Examination (CCE), by reason of my disability. I understand that ACE reserves the right to make additional inquiries regarding my disability and previous accommodations before making a determination as to whether to provide the accommodations I have requested above. Under penalty of perjury, I declare that the foregoing statements, and those in any required accompanying documents or statements, are true. I understand that false information may be cause for denial or revocation of certification. I hereby certify that I personally completed Section 1 of this form, and that I may be asked to verify this information at any time.

Candidate Signature: _____ Date: _____

I hereby authorize and request the health care professional indentified in Section 2 to release the information requested by ACE relating to my disability and the accommodation appropriate to my disability to sit for the ACE Comprehensive Certification Examination (CCE).

Candidate Signature: _____ Date: _____

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SECTION 2: To be completed by healthcare professional

Dear Healthcare Professional:

The individual identified above is requesting accommodation to sit for the ACE Comprehensive Certification Examination (CCE). ACE's policy requires that candidates requesting special testing accommodation submit current documentation of the disability from an individual qualified to assess the disability. The individual listed above is requesting that you provide such documentation. You must complete the following:

1. **The remainder of this form (Section 2).**

2. **An evaluation, on professional letterhead, that includes the following information. If submitting an existing report, it must have been written within the past three (3) years.**

   a. Confirmation of diagnosis and functional impairment
   - ☑ Date (month/day/year) of first consultation
   - ☑ Date (month/day/year) the individual was last seen by you
   - ☑ Diagnosis, summary history, and course of the disability
   - ☑ Individual's current functioning and limitations in major life activities
   - ☑ Diagnostic tests administered, scores, and interpretation of scores

   b. Confirmation of Treatment
   - ☑ Name and title of the professional
   - ☑ Duration of treatment
   - ☑ Outcomes of treatment

   c. Recommended Accommodation
   - ☑ The healthcare provider's specific recommendation for accommodation(s) that directly relates to the impairment, and is supported by functional information in the evaluation. <u>The file is considered incomplete if this specific recommendation is not included.</u>

Name: _____

Title/Occupation: _____

Address: _____

City: _____

State/Province: _____

Zip/Postal Code: _____

Country: _____

Phone: _____

Fax: _____

Are you licensed/certified in an area that allows you to diagnose the disability? ❑ Yes ❑ No

If yes, please provide your:
Jurisdiction:

License/Certification Number:

If no, please identify the credentials that allow you to diagnose the disability:

Please read and sign the following declaration:

I hereby certify that the above information is true and is given pursuant to the authorization to release information by my patient. Under penalty of perjury, I declare that the foregoing statements and those in any required accompanying documentation are true. I hereby certify that I personally completed Section 2 of this form, and that I may be asked to verify the above information at any time.

Signature: _____

Print Name: _____

Date: _____