

Institute for the Certification of Pharmacy Technicians

2536 S Old Hwy 94, Suite 224, St. Charles, MO 63303

ATTN: ADA Officer

Phone: 314-442-6775

Fax: 866- 203-9213



**Request for Special Accommodations
Under the Americans with Disabilities Act**

Policy: Candidates with documented disabilities (including learning disabilities, reading disabilities, visual impairment, hearing impairment, or other physical or mental disabilities) will be given special accommodations upon request, in conformance with the Americans with Disabilities Act (ADA).

- Please read, check the boxes and sign at the bottom of page 2.
- Please submit this form to the address at the top.
- Have your physician, or other professional as appropriate, submit the required documentation to the address above ATTN: ADA Officer.

Name:		
Address:		
City:	State:	Zip:
Telephone (home)	Telephone (other)	
Email address:		
Physician or other health professional who can verify the disability or providing other information to support this request.		
Name:		
Address:		
City:	State:	Zip:
Telephone (home)	Telephone (other)	
Please describe your disability:		
Date diagnosed:		
Previous accommodations received:		
What is your specific request:		

Please confirm the following:

I have provided a copy of these requirements to the appropriate professional and requested a letter be sent to ICPT on official stationary that provides evidence of a prior diagnosis or accommodation. **(Note: This letter is required.)**

This letter must include the following:

- the specific disability/diagnosis,
- the approximate date when the disability was first diagnosed,
- the method used to confirm the diagnosis,
- a brief description of the disability,
- the type of accommodation needed by the candidate, and
- the signature of the professional.
- Candidates requesting accommodation because of an emotional disability must have a SSM-IV classification of the diagnosis specified in the letter.
- Generally, candidates will be provided 1 ½ times the standard allotted time to complete the exam. If more time is needed, the above letter should address why.

I have attached previous school records that document the disability. (Optional)

Please check box

I understand that ICPT will use the information obtained by this authorization to determine eligibility for a reasonable accommodation in regard to the Exam for the Certification of Pharmacy Technicians (ExCPT), by reason of my disability. I understand that ICPT 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 this form, and that I may be asked to verify this information at any time.

Please check box

Authorization for Release of Information

If clarification of further information regarding the documentation provided is needed, I authorize the Institute for the Certification of Pharmacy Technicians (ICPT) to contact the professional(s) who diagnosed the disability and/or those entities who have provided me test accommodations. I authorize such professional(s) and entities to communicate with ICPT in this regard to provide ICPT with such clarification and/or further information.

Signature

Date