The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure

Board of Registration in Pharmacy
239 Causeway Street, Suite 200, 2nd Floor
Boston, MA 02114
http://www.mass.gov/reg/boards/ph
(800) 414-0168 (office) / 617-973-0983 (fax) / 617-973-0985 (TTY)

APPLICATION FOR DISABILITY ACCOMMODATION
PHARMACY LICENSING EXAMINATIONS

APPLICANT STATEMENT

Name_____

Address_____

Telephone Number ( )_____Birth date _____

Examination: NAPLEX_____MPJE_____Test Dates_____

Description of disability and how it impacts taking examinations_____
_____
_____
_____
_____

Physician, Therapist, or Other Health Care Practitioner
(List additional practitioners on a separate sheet of paper and attach to this form).

Name_____
Office Address_____
Length of Time as Patient_____

Type of Accommodation you are requesting._____
_____
_____
_____

If you have previously been provided with test accommodations, please list the test provider(s) and describe the accommodations you received. _____
_____
_____
_____

I authorize the practitioner(s) listed above to release to the Massachusetts Board of Pharmacy or its legal representative any and all information in his or her possession about my disability described above. "Information" means all information in the possession of or derived from providers of health care regarding my medical history, mental or physical condition, or treatment. I agree that this authorization shall be valid until cancelled in writing by me.

I understand that the Board of Pharmacy will use the information obtained by this authorization to determine eligibility for a reasonable accommodation with regard to the pharmacist licensure examination by reason of my disability. The Board reserves the right to require additional information or documentation to support this request for accommodation. The Board will not release any information obtained to any person or organization, except to NABP (the test developer), or any government agency that may be involved with my application to take the pharmacist licensure examination. Under penalties of perjury, I declare that the foregoing statements and those in any accompanying documents or statement are true. I understand that false information may be cause for denial or loss of a license. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time.

Signature_____

Subscribed and sworn to before me this_____day of_____20_____

Notary Public_____

APPLICATION FOR DISABILITY ACCOMMODATION
PHARMACIST LICENSING EXAMINATION

The person named below is an applicant for the Pharmacist Licensing Examination and is requesting a testing accommodation. Please complete this form and return it to the student.

_____ _____

Applicant Name (please print) Applicant Signature

PRACTITIONER STATEMENT

Practitioner Name_____

Professional Title_____

Office Address_____

_____

Phone Number_____ State License Number (if applicable)_____

Date Patient/ Applicant's First Consultation_____ Date Patient/ Applicant's Last Visit _____

Diagnosis of Disability and Basis for Diagnosis_____

_____

_____

_____

_____

Recommended Accommodation_____

_____

_____

_____

_____

Certification

I hereby certify that the above information is true and is provided pursuant to the authorization to release information by my patient. I also certify that I have the necessary specialized training to make the above diagnosis, that I personally examined the individual named above, and that the above diagnosis and assessment of accommodation request is my professional judgment. I understand that the Board of Pharmacy may contact me (with the applicant's permission) to obtain further information if necessary, and that the Board may obtain an independent assessment by another professional.

Practitioner's Signature_____ Date _____

APPLICATION FOR DISABILITY ACCOMODATION
PHARMACIST LICENSING EXAMINATION

The student named below is an applicant for the Pharmacist Licensing Examinations and is requesting a testing accomodation. Please complete this form and return it to the student.

_____ _____

Student/Applicant Name (please print) Student/Applicant Signature

COLLEGE STATEMENT

College Name_____

Name of Person completing this section_____

Title of Person completing this form _____Phone Number_____

Please describe the accommodation(s) given to this student at your institution._____
_____
_____
_____
_____

The accommodation was ____ a one-time event OR ____ an on-going accommodation.

What information/documentation was the basis for this approved accommodation? _____
_____
_____
_____
_____

Certification

I hereby certify that the above information is true and is provided pursuant to the authorization to release information by student named above. I understand that the Board may contact me (with the student's permission) to obtain further information if necessary.

School Official's Signature_____ Date _____