ADA ACCOMMODATION REQUEST FORM FOR TESTING WITH THE MISSISSIPPI STATE BOARD OF MASSAGE THERAPY (MSBMT)

If you have a disability covered by the Americans with Disabilities Act of 1990 (ADA) and would like to request an accommodation in testing, please complete Section 1 below and have an appropriate professional (education professional, doctor, psychologist, psychiatrist) with current knowledge of your disability complete Section 2 below to certify that your disability requires the requested test accommodation. As provided in Section 2 below, please also have this professional attach a letter detailing the specific nature of your disability as it relates to the request and the reasons for requesting the accommodation. The letter must be written on the professional's letterhead, must have an original signature and must be dated no more than three (3) years prior to the Application. (If you have existing documentation of having the same or similar accommodation provided to you in another testing situation, you may submit such documentation instead of having this portion - Section 2 - of this form completed.)

If any of the items are not completed and included, your request will not be processed.

SECTION 1 – TO BE COMPLETED BY CANDIDATE **PLEASE TYPE OR PRINT CLEARLY OR FILL OUT ONLINE. Print, sign and send completed document to MSBMT.**

Anticipated Test Date with the MS State Board of Massage Therapy _____

Full Name: _____

Social Security Number: _____ Email Address: _____

Mailing Address: _____

Physical Address: _____

City, State, Zip _____

Phone Number: _____ Alternate Phone Number: _____

Disability: _____

ADA Accommodation(s) Request:

Did you receive ADA Accommodation(s) during education/training? ☐ YES ☐ NO

If yes, please describe the specific ADA accommodation(s) received.

By signing below, I attest that the information I have provided on this application is accurate, true and correct to the best of my knowledge. I agree to and authorize the release of the information requested to the MSBMT for use in determining eligibility for the requested accommodation in testing. If the information provided is not sufficient to evaluate the request, I authorize MSBMT to obtain additional information from the professional who completes the documents on my behalf related to this request. In addition, I authorize that professional to provide the additional information to MSBMT if necessary for evaluating the appropriateness of my requested accommodation in testing. I understand that the MSBMT reserves the right to verify any and all information in my application, this request or in connection with my certification. Therefore, I understand and agree that my failure to provide accurate, true and correct information shall constitute grounds for rejection of my application, request for this accommodation in testing or denial or revocation of my license.

Signature:	
Date:	

SECTION 2 – TO BE COMPLETED BY APPROPRIATE PROFESSIONAL **PLEASE TYPE OR PRINT CLEARLY**

I have known _____ (full name of candidate) since

_____ (date) in my role as a _____ (professional title).
The candidate has discussed with me the nature of the MSBMT examination to be administered. It is my opinion that because of this candidate's disability as detailed on the attached letter, he/she should be accommodated by providing the following: (please check all that apply)

Reader Scribe **Extended Time** **Time-and-a-half**
Double Time **Separate testing area**
More than double time (please justify)
Use of computer or other adaptive equipment (please specify) _____

Other (please specify) _____

Name: _____

Signature: _____Date: _____

Title: _____

License Number: _____ State of License: _____

Organization: _____

Address: _____

City: _____State: _____Zip _____

Phone: _____ Fax: _____ Email Address: _____

Please attach a letter detailing the specific nature of the candidate's disability as it relates to the request and the reasons for requesting the accommodation. The letter must be written on your professional letterhead, must have an original signature and must date no more than three (3) years prior to the application

Please mail all materials to:

Mississippi State Board of Massage Therapy
Post Office Box 20
Morton, MS 39117