

CANDIDATES WITH DISABILITIES – REQUEST FOR ACCOMMODATIONS

The California Fair Employment and Housing Act¹ (“FEHA”) grants qualified individuals with disabilities who participate in the examination process protection from unlawful discrimination.

More specifically, the FEHA protects individuals with physical or mental disabilities, cosmetic disfigurement or anatomical loss or individuals regarded as or with a record of any disability who is able to perform the essential functions in an examination setting for the NCLEX-RN with or without an accommodation. A disability is a limitation of a major life activity that makes achievement difficult, requires special education or services, or affects social activities or interactions. Impairments that are not disabilities are sexual behavior disorders, compulsive gambling, kleptomania, pyromania, substance abuse disorders resulting from current and unlawful use of controlled substance.

While the board is not required to allow an accommodation that fundamentally alters the nature of the examination, the board will grant any reasonable accommodation and engage in an interactive process with each applicant who requests an accommodation to ensure that individuals with disabilities are able to meaningfully participate in the examination process.

The board will make any reasonable modifications to its policies, practices, and procedures to accommodate an individual with a disability.

The board is not able to provide reasonable accommodations to individuals unless the board is made aware of the individual's need. An applicant who needs an accommodation to be able to participate in the examination, must advise the board by the time of application for the examination. This notification should include sufficient documentation to enable the board to determine whether or not the requested accommodation is reasonable and will not fundamentally alter the nature of the examination.

The board is prohibited by law from requiring an individual with a disability to accept an accommodation if the individual chooses not to accept it.

If you have a disability which may require accommodations of the examination process or access to the examination center, you must submit with your application the following REQUIRED information:

1. A **Request For Accommodation Of Disabilities** form completed and signed by the applicant.
2. A **Professional Evaluation And Documentation Of A Disability** form completed and signed by a professional evaluator or equivalent information on original letterhead stationery of the evaluator.
3. If applicable, a **Nursing Program Verification** form indicating what accommodation(s) were granted in testing procedures during the nursing program. This form should be completed and signed by the nursing program Dean or Director or their designee or equivalent information on original letterhead stationery of the nursing program.

The required information must be completed and submitted with your application or your examination could be delayed. If you have any questions, you may contact the Testing Coordinator by writing to the Board address, Attn: Testing Coordinator, or by calling (916) 322-3350.

Any examination accommodations, including aids brought into the testing center must have **pre-approval** of the Board.

¹The California Fair Employment and Housing Act as amended by AB2222, Government Code section 12900 et seq. effective January 1, 2001, grants applicants participating in a licensure examination more protection from unlawful discrimination than the federal Americans With Disabilities Act.



BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8637 | www.rn.ca.gov

REQUEST FOR ACCOMMODATION OF DISABILITIES

In compliance with the California Fair Employment and Housing Act (FEHA), the Board of Registered Nursing (the Board) provides reasonable accommodations for applicants with disabilities that may affect their ability to take the required examination (NCLEX-RN). It is the applicant’s responsibility to notify the Board of needed alternative arrangements. The Board is not required by the FEHA to provide accommodations if we are unaware of your needs. **If you have a disability for which you wish to request accommodation(s), please provide the following information and return this form as well as all other required documentation to the Board with your application.** You may attach additional pages if necessary. Accommodations will not be provided at the examination site unless this form and all other documentation is received at the time of submission of the application. This form and all supporting documentation will become part of your examination record but will be purged from your file when you have passed the examination.

In order to grant testing accommodations, the Board must submit documentation to the National Council of State Boards of Nursing (NCSBN). The information requested below and any documentation regarding your disability will be considered strictly confidential and will only be shared with NCSBN and the testing service who will administer your examination. Please sign your name at the bottom of this form to indicate your permission for the Board to share information about your disability with NCSBN and the testing service.

NAME: _____
(First) (Middle) (Last)

ADDRESS: _____
(Street) (City) (State) (Zip Code)

DAYTIME PHONE #: _____ SSN: _____
(Area Code)

NOTE: It will be necessary for testing staff to speak and correspond with you regarding specific arrangements, therefore, it is important that you provide a current address and daytime telephone number.

1. Describe your type of disability (e.g., physical, mental, learning) and how this disability limits a major life activity that makes achievement difficult, requires special education or services, or affects social activities or interactions:

2. Explain the nature and extent of your disability (e.g., hearing impaired, diabetic, dyslexic, etc.) and how it will affect your ability to take the examination:

NAME OF APPLICANT: _____

3. Based on the disability you have described above, specify the accommodation(s) you are requesting, given the format of the examination (your request must be specific). If you request additional testing time, indicate how much:

SIGNATURE: _____ DATE: _____

NOTE: *Your signature is necessary to allow the Board permission to share pertinent information related to your disability with the NCSBN to verify the availability of the accommodation(s) and to the testing service to provide the accommodation(s). All documentation will be considered strictly confidential.*

REQUIRED DOCUMENTATION FOR ACCOMMODATION REQUESTS

You are required to submit documentation from a professional evaluator as defined on the Professional Evaluation and Documentation of Disability form. Verification of the disability must be submitted to the Board of Registered Nursing (the Board) and include the following:

- ◆ Completed **Professional Evaluation and Documentation of Disability** form or all information requested must be provided on the original letterhead stationery of the evaluator.
- ◆ Completed **Nursing Program Verification** form if you were granted testing accommodations for examinations during your nursing program.

You are solely responsible for any costs you may incur in obtaining the required documentation. However, the Board will pay for any testing accommodations that are made for you.

The Board will engage in an interactive dialogue to ensure that your request is processed in accordance with the FEHA requirement.

In order to make the necessary arrangements to accommodate your needs, all requests and supporting documentation must be sent to the Board with your application. The Board must approve all accommodations prior to your test date.

The Board will consider all requests on a case-by-case basis.

You will receive written confirmation of your approved accommodations.

Any inquiries related to accommodations may be directed to the Testing Coordinator at (916) 322-3350.

RETURN THIS COMPLETED FORM AND THE DOCUMENTATION LISTED ABOVE WITH OUR APPLICATION TO:

Board of Registered Nursing
P.O. Box 944210
Sacramento, CA 94244-2100



PROFESSIONAL EVALUATION AND DOCUMENTATION OF A DISABILITY

This form is to be completed by a professional evaluator as described on the reverse of this form. An original submission of this form by an evaluator is optional. However, if this form is not used, all of the information requested must be provided on original letterhead stationery of the evaluator or the request for accommodation(s) will be incomplete and will not be processed.

Candidate Name: _____ Birthdate: _____
(First) (Middle) (Last) (Month) (Day) (Year)

1. Describe the candidate's diagnosis or type of disability (e.g., physical, mental, learning), DSM code, if applicable, date of assessment, the tests used to assess the disability and a summary of the interpretation of the test results.

2. Describe the nature and extent of the disability (e.g., hearing impaired, diabetic, dyslexia; severe, moderate, mild), how the disability is a limitation of a major life activity that makes achievement difficult, requires special education or services, or affects social activities or interactions, and if the disability will change in any way over time. In the case of a learning disability, include specifics as to the area of the disability (e.g., visual speed, processing, memory, comprehension, etc.).

3. What is the effect of the disability on the candidate's ability to perform under standard testing conditions given the format of the examination? (See reverse of this page for a description of the examination format.)

4. What is the recommended accommodation(s) and how does the accommodation(s) relate to the candidate's disability given the format of the examination? The request must be specific (e.g., if additional time is needed, indicate how much).

NAME OF APPLICANT: _____

5. Describe the credentials, education and experience which qualify you, the evaluator, to make the determination of the disability and the recommended accommodation. (See below for description of a qualified evaluator.)

Evaluator's Name (Print): _____ Organization: _____

Evaluator's Signature: _____ Telephone No: _____
(Date) (Area Code)

Type of Professional License or Certificate and Number (if applicable) _____

I. Description of a Qualified Evaluator

The Board will accept evaluations from qualified evaluators. A qualified evaluator cannot be the spouse of the candidate nor related to the candidate. The evaluator must have sufficient experience to be considered qualified to evaluate the existence of and proposed accommodations needed for specific learning disabilities. Guidelines for a qualified evaluator are listed below:

(a) For purposes of physical or mental disabilities, not including learning disabilities, the evaluator is a licensed physician or psychologist with expertise in the area of the disability.

(b) In the case of learning disabilities, a qualified evaluator is one of the following:

A licensed psychologist or physician who has experience working with adults with learning disabilities and who has training in all of the areas described below

OR

another professional who possesses a master's or doctorate degree in the category of disability, special education, education, psychology, educational psychology, or rehabilitation counseling and who has training and experience in all of the areas described below:

- Assessing intellectual ability level and interpreting tests of such ability.
- Screening for cultural, emotional and motivational factors.
- Assessing achievement level.
- Administering tests to measure attention and concentration, memory, language reception and expression, cognition, reading, spelling, writing and mathematics.

II. Format of Examination

The examination contains objective multiple-choice questions, which are administered by computer in an adaptive format. The examination does not require knowledge of computer operation. The number of questions may vary from a minimum of 75 to a maximum of 265. The maximum six-hour time limit to complete the examination includes the tutorial, sample items and all rest breaks. The first preprogrammed optional break takes place after 2 hours of testing. The second preprogrammed optional break takes place after 3½ hours of testing. The examination is administered at Pearson Professional Centers, which have up to 15 individual computer workstations.



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NURSING PROGRAM VERIFICATION

This form is to be completed by the nursing program Dean or Director or their designee if accommodation(s) to testing procedures were granted to this candidate during their nursing program. Original submission of this form is optional. However, if this form is not used, all of the information requested must be provided on original letterhead stationery of the nursing program.

Candidate Name: _____
(First) (Middle) (Last)

Birthdate: _____
(Month) (Day) (Year)

Describe the format of examinations administered (e.g., written multiple-choice, essay, oral, etc.) and the accommodation(s) provided to the above candidate for these examinations during their nursing program:

Name of Person Completing Form (Print): _____

Title: _____ Name of School: _____

Telephone No: _____ Signature: _____
(Area Code) (Date)



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INFORMATION COLLECTION AND ACCESS

The Information Practices Act, Section 1798.17 Civil Code, requires the following information to be provided when collecting information from individuals.

Agency Name: BOARD OF REGISTERED NURSING	
Title of official responsible for information maintenance: EXECUTIVE OFFICER	
Address: P.O. BOX 944210, SACRAMENTO, CA 94244-2100	Telephone Number: (916) 322-3350
Authority which authorizes the maintenance of the information: SECTION 30, SECTION 2732.1(a), BUSINESS AND PROFESSIONS CODE	
ALL INFORMATION IS MANDATORY.	
The consequences, if any of not providing all or any part of the requested information: FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE.	
The principal purpose(s) for which the information is to be used: TO DETERMINE ELIGIBILITY FOR LICENSURE. YOUR SOCIAL SECURITY NUMBER WILL BE USED FOR PURPOSES OF TAX ENFORCEMENT, CHILD SUPPORT ENFORCEMENT AND VERIFICATION OF LICENSURE AND EXAMINATION STATUS. SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE AND PUBLIC LAW 94-455 (42 USCA 405(c)(2)(C)) AUTHORIZE COLLECTION OF YOUR SOCIAL SECURITY NUMBER. IF YOU FAIL TO DISCLOSE YOUR SOCIAL SECURITY NUMBER, YOU WILL BE REPORTED TO THE FRANCHISE TAX BOARD, WHICH MAY ASSESS A \$100 PENALTY AGAINST YOU. YOUR NAME AND ADDRESS LISTED ON THIS APPLICATION WILL BE DISCLOSED TO THE PUBLIC UPON REQUEST IF AND WHEN YOU BECOME LICENSED.	
Any known or foreseeable interagency or intergovernmental transfer which may be made of the information: POSSIBLE TRANSFER TO LAW ENFORCEMENT, OTHER GOVERNMENT AGENCIES AND REPORTING SOCIAL SECURITY NUMBER TO THE FRANCHISE TAX BOARD OR FOR CHILD SUPPORT ENFORCEMENT PURPOSES PURSUANT TO SECTION 30 OF THE BUSINESS AND PROFESSIONS CODE.	
EACH INDIVIDUAL HAS THE RIGHT TO REVIEW THE FILES ON RECORDS MAINTAINED ON THEM BY THE AGENCY, UNLESS THE RECORDS ARE EXEMPT FROM DISCLOSURE.	

MANDATORY REPORTER

Under California law each person licensed by the Board of Registered Nursing is a “Mandated Reporter” for child abuse or neglect purposes. Prior to commencing his or her employment, and as a prerequisite to that employment, all mandated reporters must sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Section 11166 and will comply with those provisions.

California Penal Code Section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code Section 11165.9 [generally law enforcement agencies] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as is practicably possible by telephone, and the mandated reporter must prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Section 11166 is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars (\$1,000), or by both imprisonment and fine.

For further details about these requirements, consult Penal Code Section 11164, and subsequent sections.