Louisiana State Board of Nursing
17373 Perkins Road
Baton Rouge, LA 70810
Phone: (225) 755-7500
www.lsbn.state.la.us

Request for Special Testing Accommodations for the NCLEX-RN

In accordance with the Americans with Disabilities Act (ADA) and the National Council of State Board of Nursing NCLEX Member Board Manual, the Louisiana State Board of Nursing (LSBN) will grant reasonable accommodations to qualified candidates that have a disability that may interfere with their ability to sit for the NCLEX-RN.

In order for LSBN to grant reasonable accommodations for the NCLEX-RN the following documentation must be submitted for review:

1. The candidate should submit an Application for Licensure as a Registered Nurse by Examination, in which the candidate will indicate the need for special testing accommodations by answering Yes to question 11, *Do you require special testing accommodations?*

2. The candidate should submit the *Request for Special Testing Accommodations for the NCLEX-RN* – Candidate Form, Nursing Program Verification, and Diagnostician Form. (This form should be submitted with the application).

When requesting special testing accommodations for the NCLEX-RN please keep the following in mind:

1. The NCLEX-RN has a time limit of six (6) hours for all candidates.
2. All candidates can take an unlimited number of breaks during the exam, but all breaks will count toward the total maximum time of 6 hours.
3. Test anxiety is not a recognized diagnosis according to the DSM-IV-TR and does not qualify as a covered disability.
4. English as a Second Language (ESL) falls outside the coverage of the ADA as the regulatory definition of a disability under the Rehabilitation Act and the ADA confirms that cultural factors, such as an individual's language, cannot form the basis for a claim of disability.

Please note that if there is information in the accommodation request that indicates the candidate's condition poses a risk to the health, safety and welfare of patients or the public that information will be provided to the investigations department and an investigation may be conducted.

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Candidate Form

Candidate Information
(Please Print and use full legal name)

Name: _____

Address: _____

Phone: _____ DOB: _____

Name and Type of Nursing Program: _____

Date of Graduation: _____

Disability Information

Describe your disability (e.g. physical, mental, or learning): _____

_____

_____

Which of the following major life activities are adversely affected by your disability. (Circle all that apply)

Walking	Seeing	Hearing	Speaking
Breathing	Learning	Thinking	Working
Caring for one's self		Performing manual tasks	

At what age were you initially diagnosed with your disability? _____

How long have you required testing accommodations? _____

Describe what type of testing accommodations you have previously received: _____

_____

_____

_____

Check the box next to the specific accommodation(s) you are requesting for the NCLEX-RN:

☐ Extra Time – 3 Hours

☐ Extra Time – 2 hours

☐ Extra Time – Double Time Over 2 Days

☐ Extra Time - Other

☐ Separate Room

☐ Separate Room & Reader

☐ Separate Room & Recorder

☐ Separate Room & Sign Language Interpreter

☐Adjustable Contrast

☐ Adjustable Font Size

☐ Screen Magnifier

☐ Aid

☐ Equipment

☐ Other, explain _____

_____ _____

Signature Date

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Nursing Program Verification

This form should be completed by the Dean or Director of the nursing program.

Candidate Information

Candidate Name: _____

Candidate DOB: _____

Accommodation Information

Were testing accommodations provided to this candidate while enrolled in the nursing education program? YES NO

Describe the types of examinations (e.g., multiple choice, essay, etc.) that were administered by the nursing education program, and what accommodations were provided to the candidate.

_____

_____

_____

_____

Nursing Program Information

Name and Type of Nursing Education Program: _____ Name of Dean/Director: _____

(SEAL)

_____ _____

Signature Date

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Diagnostician Form

The diagnostician completing this form must be a qualified professional that is licensed or otherwise properly credentialed professional that possess expertise in the disability for which modifications or accommodations are sought.
For physical or mental disabilities other than learning disabilities this form must be completed by a licensed physician, psychologist, advanced practice registered nurse with certification and/or expertise in the area of the candidate's disability.
For learning disabilities this form must be completed by a licensed psychologist, psychiatrist, or other qualified professional with a master's or doctorate degree in special education, education, psychology, educational psychology, rehabilitation counseling or in a field specific to the diagnosis and treatment of the candidate's learning disability.

Student Consent to Disclosure of Medical Information and Records

I, _____ do hereby authorize all of my health care providers to disclose and
(PRINT NAME)
furnish any and all information, records, and opinions, any reports or summaries thereof, whether in electronic form or otherwise, relating to my evaluation, diagnosis, treatment and prognosis by or under the care of the health care provider, to the Louisiana State Board of Nursing, and any representatives thereof (collectively referred to as the "Board"), for the purpose of permitting the Board to be initially and periodically advised of my diagnosis, treatment and prognosis for any condition, including but not limited to my disability which may impair my capacity my ability to participate in clinical nursing education, test, or practice nursing with reasonable skill and safety to patients or to myself. _____ (signature and date)

Disability Information

Date of initial diagnosis: _____

Diagnosis Code (DSM or ICD-9): _____

Diagnosis – provide the specific diagnosis of the candidate's disability _____

_____

Which of the following major life activities are adversely affected by the candidate's disability. (Circle all that apply)

Walking	Seeing	Hearing	Speaking
Breathing	Learning	Thinking	Working
Caring for one's self		Performing manual tasks	

Did you conduct and individualized assessment on this candidate? Yes No

If Yes, list the specific type of assessment(s) conducted (e.g. Woodcock-Johnson, Weschler Adult Intelligence Scale) and provide a copy of assessment if available:

_____

_____

Provide summary of current treatment plan including all medications prescribed for treatment of the candidate's disability: _____

_____

_____

_____

_____

Provide a detailed summary of the required accommodation(s) for this candidate:

_____

_____

_____

Diagnostician Information

Diagnostician
Name: _____ Title: _____
(Please print or type)

Address: _____

_____

Phone: _____

Type of Professional License: _____

License Number: _____

State of Licensure: _____

Specialty Certification/Qualifications: _____

_____ _____
Signature Date

EX03
REV - 8/6/2013, 6/24/14, 1/22/16