PROFESSIONAL DOCUMENTATION OF DISABILITY

NORTH DAKOTA BOARD OF PHYSICAL THERAPY

SFN 59670 (11-2010)

Section I - Applicant Information

Name (Last, First, Middle)	Date of Birth	Social Security Number
ExamType ☐ Physical Therapist (PT) ☐ Physical Therapist Assistant (PTA)		

In compliance with the Federal Privacy Act of 1974, applicants are advised that the disclosure of an individual's social security number on this form is mandatory under §43-50-02 of the North Dakota Century Code. The number is used for identification purposes and for testing and licensing through the Federation of State Boards of Physical Therapy. The penalty for not including the number is the inability of the applicant to be tested and licensed as a physical therapist.

Section II - About the Exam

The examination for which this candidate is requesting special accommodations consists of objective multiple choice questions which are administered by computer at a testing center. Minimal computer skills are required.

Standard Testing Conditions

Exam	Number of Questions	Time Allowed	Scheduled Breaks	Unscheduled Breaks
PT	250 (delivered in 5 sections of 50 questions each)	5 hours	15 minute break after section 2	Breaks can be taken after sections 1,3, and 4; however, the exam timer will continue to elapse
PTA	200 (delivered in 4 sections of 50 questions each)	4 hours	15 minute break after section 2	Breaks can be taken after sections 1 and 3; however, the exam timer will continue to elapse

Section III - Professional Contact and Background Information

Name	Title	License Number	Expiration Date
Address	City	State	ZIP Code
Email	Telephone Number	Fax Number	

Please describe your credentials and experience which qualify you to make this diagnosis and recommendations for testing. You may also attach your Curriculum Vitae to show this information.

Section IV - Disability and Requested Accommodation

Describe the Diagnosed Disability. Attach all written evaluations supporting the diagnosis, including the scores and interpretive data for all administered diagnostic tests.	Date of Diagnosis
	Date of Last Consultation with Candidate

Please describe: (1) the nature, history, and extent of the disability; (2) how it limits one or more of the candidates major life activities; (3) if the disability will change in any way over time. In case of a learning disability, include specifics as to the type of disability (e.g., visual or auditory reception or perception, processing, memory, comprehension, verbal or written expression, etc.)

Describe the effect the disability has on the candidate's ability to perform on the test described on the previous page.

Mark your specific recommendations for accommodations for this candidate.

- ☐ Additional Time - Time and a half
- ☐ Reader
- ☐ Zoom Text
- ☐ Screen Magnifier
- ☐ Additional Time - Double Time
- ☐ Scribe
- ☐ Separate Room
- ☐ Other - Specify:

Please include as explanation of why these accommodations are required.

I certify that I have the necessary specialized training to make the above diagnosis, that I personally examined the candidate named above, and that the diagnosis and assessment of accommodations requested are based on my professional judgment. I understand that the candidate has authorized me to provide the information on this form, and to provide further information if necessary.

Printed Name	
Signature	Date