# Request for Test Accommodations Form
## Horticultural Therapist – Board Certified (HT-BC)

American Horticultural Therapy Association®

The American Horticultural Therapy Association (AHTA) supports the intent of and comply with the Americans with Disabilities Act (ADA) and will take steps reasonably necessary to make testing accessible to persons with disabilities covered under the ADA. All approved testing accommodations must maintain the psychometric nature and security of the exam.

Candidates requesting Testing Accommodations **MUST** complete and submit this form and wait for approval of accommodations **PRIOR TO** scheduling an exam appointment with Prometric.

The Request for Test Accommodations Form must be uploaded with the candidate's HT-BC application and fees **at least 8 weeks before the start of your testing window.** Missing information or incomplete forms will result in a delay in processing. Please review the HT-BC Candidate Handbook for the full Testing Accommodations policy.

### Section 1. Applicants/Candidate Information

First Name | Last Name

Primary Mailing Address

City | State/Province | Zip/Postal Code | Country

Phone Number | Email

## Section 2. Testing Accommodations Request

Have you ever been granted testing accommodations?

- ☐ YES
- ☐ NO

If YES, please document at least one instance where testing accommodations for a similar testing experience were granted.

| Year of Accommodation | Type of Accommodation | Name of Institute/Organization that Provided Accommodation |
|---|---|---|
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By submitting this document, I consent to the transfer, collection, processing and use of my information by the American Horticultural Therapy Association (AHTA) in accordance with the AHTA Privacy Policy, and solely for the purpose of evaluating and providing the above-requested accommodation(s). Further, I understand that the AHTA may disclose and transfer such information to our testing vendors.

Printed Name

Signature Date

## Section 3. Professional Evaluation (to be completed by a qualified health care professional)

DOCUMENTATION OF DISABILITY-RELATED NEEDS BY QUALIFIED PROFESSIONAL*

A qualified health care professional (i.e., physician, psychologist, psychiatrist) must complete this section to ensure that the AHTA is able to provide the appropriate accommodations for taking a multiple choice exam, or for providing the appropriate certification policy modifications.

| Name of Professional | | Title | Occupation |
|---|---|---|---|
| Primary Mailing Address | | | |
| City | State/Province | Zip/Postal Code | Country |
| Phone Number | | Email | |

*MUST be licensed/certified to assess, diagnose and treat the stated disability.

The following information must be included in the description below: (1) the length of time you have treated the candidate and whether treatment has ended or is ongoing, (2) the nature of the disability as it relates to the candidate's ability to sit for the exam or comply with the applicable policy, (3) a description of how the disability has affected or will affect the candidate's ability to sit for the exam or comply with the applicable policy, (4) how long you expect the candidate's limitations to continue, such that they will continue to require the testing accommodation or modification of the applicable policy, and (5) the specific test accommodations or policy modifications requested.

Description of Disability

*(Form continues on the next page)*

Accommodation(s) Requested

Date of Diagnosis/Onset

License/ Certification Number Expiration Date

I have evaluated _____Candidate's Name_____ on ____/____/____ in my capacity of this applicant's disability, described above, he or she should be provided with the testing accommodations and/or policy modifications indicated.

The candidate discussed with me that a multiple choice exam was, or will be, administered. It is my professional opinion that because of this applicant's disability, described above, he or she should be provided with the testing accommodations and/or policy modifications indicated.

Signature Date