BOARD *for* CERTIFICATION
of NUTRITION SPECIALISTS℠

Documentation of Disability-Related Needs Form

If you have a disability covered by the Americans with Disabilities Act (ADA), please complete the Special Accommodations Request Form and Documentation of Disability-Related Needs Form. The information you provide, and any documentation regarding your disability and special accommodations request, will be treated with strict confidentiality. Please have this section completed by a licensed healthcare provider to ensure the BCNS is able to provide the required testing accommodations.

Licensed Healthcare Provider Documentation:

I have known _____ since _____/_____/_____
(Test Applicant Name)

in my capacity as a _____
(Professional Title)

Special Accommodations:

The applicant has discussed with me the nature of the test administered. It is my professional opinion, that because of the applicant's disability, _____ should be accommodated by providing the following *(check all that apply):*

☐ Accessible testing site
☐ Separate testing room
☐ Extended testing time
☐ Screen magnifier (large font)
☐ Reader required for learning
☐ Reader required for visual

Other: _____

_____

_____

Comments: _____

_____

_____

Signature: _____ **Date:** _____

Title: _____ **License #:** _____
(if applicable)

Form submission: Please email to Applications@NutritionSpecialists.org