NCEES HEALTHCARE PROVIDER FORM

Patient's Full Name: _____

Patient's Date of Birth: _____

Patient's Telephone #: _____

Patient's Email: _____

Purpose of this Form:

The National Council of Examiners for Engineering and Surveying (NCEES) is a private, non-profit organization that develops standardized examinations. The examinations are used by jurisdictions across the country to help evaluate the qualifications of individuals who are seeking to become licensed professionals in the fields of engineering or surveying.

The purpose of this form is to obtain information that will be relied upon by NCEES in determining whether a licensure candidate needs testing accommodations because he or she has a physical or mental impairment that rises to the level of a disability. Accommodations are intended to level the examination playing field. Given the important role that licensing exams play in protecting the health and safety of the public, accommodations are warranted only when a candidate provides reasonable documentation from a qualified professional who has diagnosed the candidate as having a physical or mental impairment that substantially limits the candidate's ability to perform one or more major life activities that are relevant when taking an examination.

Instructions:

Please complete this form in a legible manner, sign it, and return it to the candidate along with any test results, evaluation reports, or other documentation prepared as part of your examination and evaluation of the candidate that you believe is necessary to support the candidate's accommodation request(s). The candidate will provide the form and other documentation (if any) to NCEES.

If not already provided to you by the candidate, NCEES's documentation guidelines for specific types of impairments can be found at this web address:

https://ncees.org/exams/reasonable-accommodations/ada-exam-accommodations/

HEALTHCARE PROVIDER INFORMATION

(To be completed by qualified healthcare provider)

Name:		Credentials and Licensing Information:
Address:		
Phone:	Fax:	Email:

DISABILITY ASSESSMENT

1. What is the specific diagnosis? Please also provide the relevant DSM-5 or ICD code:

2. When was the diagnosis(es) made?	3. When did you last see the patient?

4. How did you make the diagnosis: What tools or methods were used to evaluate the patient and his or her symptoms? If you and the patient are relying on assessment results to support the patient's accommodation request, please provide the results from any such assessments that were administered in making your diagnosis.

5. Please describe the current symptoms this patient experiences as a result of the diagnosed impairments(s), particularly as they relate to the patient's ability to take a multiple-choice examination and respond to essay questions under standard testing conditions.

6. What major life activities are affected by the diagnosed impairment(s) and/or treatment plan? (check all that apply)

☐ Caring for oneself	☐ Bending
☐ Performing manual tasks	☐ Speaking
☐ Seeing	☐ Breathing
☐ Hearing	☐ Learning
☐ Eating	☐ Reading
☐ Sleeping	☐ Concentrating
☐ Walking	☐ Thinking
☐ Standing	☐ Communicating
☐ Sitting	☐ Working
☐ Reaching	☐ Interacting with Others
☐ Lifting	☐ Operation of a major bodily function

7. What is the current treatment or medication plan?

8. Does the patient's medication and/or treatment plan affect his/her ability to take a multiple-choice examination under standard testing conditions? If so, how?

9. What testing accommodations do you recommend as a reasonable means of addressing the patient's symptoms?

By signing below, I am verifying that (1) the diagnosis(es) and supporting information provided are accurate; and (2) I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Healthcare Provider Signature: _____ **Date:** _____

MOBILITY ASSESSMENT SUPPLEMENT

(Complete only for conditions affecting patient's ability to access physical spaces)

1. Is the patient able to climb or descend stairs? (check one)

   ☐ Yes
   ☐ No

2. Does the patient use an assistive mobility device, personal attendant, or service animal? If so, please identify.

3. Does the patient have a current need for any of the items listed below? (check all that apply)

   ☐ Adjustable chair
   ☐ Sit/stand desk
   ☐ Podium
   ☐ Other (please specify below)

By signing below, I am verifying that (1) the diagnosis(es) and supporting information provided are accurate; and (2) I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Healthcare Provider Signature: _____ **Date:** _____