Oregon Health Authority
HEALTH LICENSING OFFICE
1430 Tandem Ave. NE, Suite 180, Salem, OR 97301-2192
Phone: 503-378-8667 | Fax: 503-370-9004
www.healthoregon.org/hlo Email: hlo.info@state.or.us

Print Form

ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for special arrangements or accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission.

Applicant Information:

NAME: LAST	FIRST	MIDDLE INITIAL
RESIDENTIAL PHYSICAL ADDRESS **(REQUIRED)**		
CITY	STATE	ZIP
MAILING ADDRESS (IF DIFFERENT FROM PHYSICAL ADDRESS)		
CITY	STATE	ZIP
PHONE: ☐ HOME ☐ CELL	SOCIAL SECURITY# **(REQUIRED)**	
EMAIL:		

As per my licensure/examination application, I am applying for accommodations for a State approved examination administered by the Health Licensing Office (HLO):

Examination Type: ☐ **Written** and/or ☐ **Practical**

➲ **Applicant Signature:**_____ **Date:**_____

If you have a learning disability, a psychological disability, or a disability that requires an accommodation in testing, have the appropriate professional (i.e., doctor, psychologist, psychiatrist, etc.) complete the reverse side of this document and remit with supporting documentation to confirm your accommodation needs. If you have existing documentation of your accommodation needs, you may submit such documentation instead of completing the next page of this form. Please include all information to support your accommodation request. HLO may contact you if additional information is needed, however, if additional information is needed to process your request, it may delay your examination date.

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DOCUMENTATION OF DISABILITY RELATED NEEDS

To be completed by the appropriate professional ***(e.g. doctor, psychologist, psychiatrist, etc.)***. Requests for accommodation must be received prior to the preferred examination date.

The applicant has discussed with me the nature of the test to be administered. It is my opinion that due to this applicant's disability, he/she may be accommodated with the following (check all that apply):

☐ Reader as accommodation for visual impairment

☐ Scribe / amanuensis as accommodation for visual or motor impairment

☐ Reader as accommodation for learning disability

☐ Scribe / amanuensis as accommodation for learning disability

☐ Sign language interpreter

☐ Use of computer or other adaptive equipment (please specify):_____

☐ Separate testing area

☐ Other (please specify):_____

☐ Extended time ☐ Time-and-a-half

☐ Double time ☐ More than double time (please justify):

Professional Title: _____License Number:_____

Name: _____

Business Address: _____

Business Phone: _____

Signature: _____ Date:_____

Please return this completed form and any supporting documentation to:
Health Licensing Office, Licensing Division
at the address listed above.

Return All Pages of this Application and Keep a Copy for Your Records