

INSTRUCTIONS

APPLICATION FOR DISABILITY ACCOMMODATIONS

ASSOCIATION OF SOCIAL WORK BOARDS

The Application for Disability Accommodations is to help the social work board in your jurisdiction determine (1) whether you are a qualified disabled individual under applicable federal, state, provincial, or local legislation and (2) whether the accommodation you are requesting is reasonable. Consideration of all requests will be made under applicable laws.

PART I: The information requested on Part I of the form is self-explanatory. You are not required to furnish your Social Security Number (US)/Social Insurance Number (Canada), but this information would be most helpful in identifying you and relating this Application for Disability Accommodations to other parts of your examination application. After you have completed Part I, the application must be dated and signed by you and notarized by a Notary Public in your jurisdiction. **ALL APPLICATIONS MUST BE SUBMITTED WITH ORIGINAL SIGNATURES. COPIES OR FAXED SIGNATURES WILL NOT BE ACCEPTED.**

PART II: Part II of this Application for Disability Accommodations should be completed by your health care practitioner or other appropriate professional and signed and dated where indicated. **ALL APPLICATIONS MUST BE SUBMITTED WITH ORIGINAL SIGNATURES. COPIES OR FAXED SIGNATURES WILL NOT BE ACCEPTED.**

SUBMISSION OF THE FORM: The ASWB examinations are offered through the relevant jurisdictional board. Although each board's application process may differ slightly, this form must be submitted before the board can make a decision on any examination accommodations requested. Parts I and II of this Application for Disability Accommodations should be mailed directly to ASWB at the address below.

EXCEPTION: For Connecticut applicants only, Part I should be submitted to the Connecticut Department of Public Health by either the applicant or the health care practitioner. **The health care practitioner MUST submit Part II directly to the Connecticut Department of Public Health.**

You must receive approval from your board and ASWB before registering for an examination. Forms not fully completed will be returned to the applicant.

Please consult with your board to determine the appropriate application process and relevant deadlines.

A submitted Application for Disability Accommodations will remain valid for one year from the date when executed by the applicant. A valid application will be considered for any examination occurring within this one-year period provided the applicant makes a request at the time of registration.

Under any circumstances, it is recommended that you maintain a copy of this form for your records. Questions may be directed to your board or to ASWB (1-800-225-6880, extension 3003).

SUBMIT PARTS I AND II OF THE APPLICATION FOR DISABILITY ACCOMMODATIONS AT THE SAME TIME

(CT applicants, see exception above)

Applications for Disability Accommodations (except for CT applicants) should be mailed to:

ASWB Candidate Registration Center

P.O. Box 1508

Culpeper, VA 22701

APPLICATION FOR DISABILITY ACCOMMODATIONS
Social Work Licensure Examination

PART I

Name: _____
Last
First
Middle/M.I.

Address: _____

City, State/Province: _____

ZIP/Postal Code: _____

Email: _____

Work Phone Number: (_____) _____

Home Phone Number: (_____) _____

Cell Phone Number: (_____) _____

Social Security Number (US)/Social Insurance Number (Canada) (Optional—see instructions)

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Birthdate: _____

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Month Day Year

Examination to be taken (check one):

Bachelors Advanced Generalist

Masters Clinical

State/province/territory to which you are applying: _____

Major life activity impaired by disabling condition:

Physicians or Other Health Care Practitioners:

(a) Name: _____ (b) Name: _____

Office Address: _____ Office Address: _____

Length of time as patient: _____ Length of time as patient: _____

Release:

I authorize each health care practitioner listed above to release to the _____ (state/province/territory) board of social work, the Association of Social Work Boards (ASWB), or their designated representatives, information which will verify the current functional limitations imposed by my disability which affect my ability to perform under standard testing conditions; and describe the nature of the examination accommodation(s) being proposed and the rationale for those accommodation(s). I further understand that I may be asked to provide additional information about my functional limitation(s) and the requested accommodations and agree to cooperate with reasonable requests for such additional information.

I understand and agree that the information obtained by this authorization will be used solely for the purpose of determining my eligibility for reasonable accommodations in regard to the social work licensure process and the nature and extent of the accommodations which are reasonably necessary by reason of my disability. The information obtained by this authorization will not be released or disclosed to any person or organization except the referenced parties, and any other governmental agency that may be involved in acting upon my request for reasonable accommodations in connection with the social work licensure process.

I agree that this authorization shall be valid until canceled or revoked in writing by me.

Under penalties of perjury, I declare that the foregoing statements and those in any required accompanying documents or statements are true. I understand that false information may be cause for denial or loss of a license. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time.

Signature: _____ Date: _____

Subscribed to and sworn to before me this _____ day of _____, 20____.

Notary Public: _____

This application is valid for a period of one (1) year from the date when first executed by the applicant. (See instructions.)

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Culpeper, VA 22701

APPLICATION FOR DISABILITY ACCOMMODATIONS
PRACTITIONER'S STATEMENT

(A copy of this form must be completed by each health care practitioner providing services to the patient.)

PART II

Practitioner Name: _____
Last First Middle/M.I.

Office Address: _____

Office Phone Number: (_____) _____

Patient's Name: _____

Patient's Address: _____

City, State/Province, ZIP/Postal Code: _____

Patient's Social Security Number (US)/Social Insurance
Number (Canada)

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Patient's Birthdate:

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Month

Day

Year

1. Diagnosis and description of disabling condition: _____

Date patient first seen: _____ Date patient last seen: _____

2. Date of onset: _____

3. Major life activity(ies) limited by disabling condition (e.g., walking, seeing, breathing, etc.) _____

4. Circumstances under which previous accommodations were granted and dates of occurrences: _____

5. Accommodation(s) needed in this testing situation: _____

I hereby certify that the above information is true and is released pursuant to authorization by my patient.

Signature of Health Care Practitioner: _____ Date: _____

Professional Status (*physician, psychologist, etc.*): _____

License Number (if applicable): _____

**CONNECTICUT APPLICANTS: This form must be sent directly to the
Connecticut Department of Public Health by the practitioner.**

FOR BOARD USE

Board approval, if applicable: _____
Name Title Date