

# 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: \_\_\_\_\_

Daytime Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Evening Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Cell Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

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

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Birthdate:

Month	Day	Year							

Examination to be taken (check one):

Bachelors       Advanced Generalist

Masters         Clinical

Jurisdiction 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 \_\_\_\_\_ (jurisdiction) 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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