INSTRUCTIONS
APPLICATION FOR DISABILITY ACCOMMODATIONS

The Application for Disability Accommodations helps ASWB and 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 (U.S.)/Social Insurance Number (Canada), but this information helps identify you and connect 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. **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.

You must receive approval from your board and ASWB before registering for an examination.

If an application is incomplete, you will be notified and given an opportunity to respond/complete it within 60 days. If not completed within the given timeframe, the application will not be processed.

A submitted Application for Disability Accommodations will remain valid for one year from the date it is 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, ext. 3250).

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

Applications for Disability Accommodations should be mailed to:

ASWB Candidate Services
P.O. Box 1508
Culpeper, VA 22701

APPLICATION FOR DISABILITY ACCOMMODATIONS
Social Work Licensing Examination

PART I

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

Address:_____

City, State/Province:_____

ZIP/Postal code:_____

Email: _____

Phone number: (_____) _____

Birthdate:

Month Day Year

State/province/territory to which you are applying:

_____

Social Security number (U.S.)/
Social Insurance Number (Canada)
(Optional—see instructions)

Major life activity impaired by disabling condition:

Physicians or other health care practitioners:

(a) Name: _____
Office address: _____
_____
_____
Length of time as patient: _____

(b) Name:_____
Office address:_____
_____
_____
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. Notwithstanding the above, ASWB reserves the right to provide accommodation requests and supporting documentation to a consulting entity for the sole purpose of obtaining expertise regarding certain requests.

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:_____

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

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. Applicant should complete the first four lines.)

PART II

Patient name: _____

Patient address: _____

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

Patient birthdate:

Month Day Year

Patient Social Security number (U.S.)/Social Insurance Number (Canada) (Optional—see instructions)

Practitioner name: _____
Last *First* *Middle/M.I.*

Office address: _____

_____

Office phone number: (_____) _____

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): _____