REQUEST FOR TEST ACCOMMODATIONS APPLICATION: COMVEX

NBOME
NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS

I, Name:

NBOME ID#:

certify that I am a "person with disabilities" as defined by the Americans with Disabilities Act, as amended (ADA), and request that the National Board of Osteopathic Medical Examiners, Inc. (NBOME) provide accommodations for me for the Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX).

I represent that because of my disability (as defined by the ADA), I cannot access the COMVEX the same as most people in the general population, and I am therefore requesting the following accommodation(s):

By completing and submitting this application, I acknowledge that I have read and understand the eligibility requirements for test accommodations under the ADA and NBOME's Instructions to Request Test Accommodations. I also acknowledge that I have read and agree to the Terms and Conditions contained in the COMVEX Bulletin of Information. I also represent, under penalty for perjury, that the information provided by me on the Request for Test Accommodations Application and in my personal statement in support of my request for test accommodations is true and correct.

Candidate's Signature:

Date:

CURRENT INFORMATION

Licensing authority requesting COMVEX: *(State Medical Board)*

Home Address:

City:

State/Province:

Zip Code:

Email Address:

Phone:

Please respond to each item in the space provided (do not write "see attached"). If there is insufficient space, include any supplemental information in your personal statement.

1. Impairment(s)

(a) Nature of each diagnosed and documented physical or mental impairment which "substantially limits" your ability to access the COMVEX: (check all that apply)

- ☐ Attention Deficit/Hyperactivity
- ☐ Hearing
- ☐ Other Physical
- ☐ Learning/Reading
- ☐ Visual
- ☐ Psychiatric Disorder

Other (please specify):

(b) Identify each qualified professional diagnosing your impairment(s) and date(s) of diagnosis:
(Attach all written evaluations of your impairment(s), including opinions of qualified professionals, and the CV or other statement of qualifications of each professional evaluator.)

Name of Evaluator:	Diagnosis:	Date of Diagnosis:

(c) Describe all real life activities adversely affected by your impairment(s):

(d) Explain, in detail, why you are unable to access the examination, as compared to most people in the general population, without the requested accommodation:

2. Prior Accommodation(s)

(a) Check and describe all standardized examination(s) you took **with** accommodations:
(Attach verification of accommodation(s) if possible.)

	Date(s)
☐ COMLEX-USA	
☐ MCAT	
☐ ACT/SAT	
☐ GRE	
☐ Medical School	
☐ College	
☐ Pre-College	
☐ Other	

(b) Check and describe all standardized examination(s) you took **without** accommodations:

	Date(s)
☐ COMLEX-USA	
☐ MCAT	
☐ ACT/SAT	
☐ GRE	
☐ Medical School	
☐ College	
☐ Pre-College	
☐ Other	

(c) If you took the MCAT, USMLE, ACT/SAT, or GRE examination, attach a copy of your score report(s) for each of those examinations.

☐ Attached ☐ N/A

(d) Have you requested any accommodation which was not provided as you had requested?

☐ Yes ☐ No

If yes, describe the circumstances:

(e) Have you received any accommodation in a clinical skills or similar examination?

☐ Yes ☐ No

If yes, describe the circumstances:

3. Supporting Documentation

Attach the following supporting documentation:

☐ Personal statement (narrative detailing why you require the accommodation)

☐ Professional evaluation(s) and CV(s)

☐ Other supporting documentation (e.g., report cards, transcripts, score reports, etc.)

4. Certification and Authorization

I, the undersigned candidate requesting an accommodation under the ADA, certify, under penalty for perjury, that all the foregoing representations and accompanying documentation are true and complete.

Candidate's Signature: Date: