



## ONCC Testing Accommodations Request Form

The Oncology Nursing Certification Corporation (ONCC) will provide reasonable accommodations for test candidates with disabilities that are covered under the Americans with Disabilities Act (ADA), as amended. Candidates requesting testing accommodations must submit the Testing Accommodations Request Form by mail or fax within five business days of applying. Reasonable accommodations are generally provided for candidates who have a physical or mental impairment that substantially limits that person in one or more major life activities (e.g., walking, talking, hearing, performing manual tasks), have a record of such physical or mental impairment, or are regarded as having a physical or mental impairment that prevents them from taking the test or assessment under standard conditions. In addition:

1. You must complete and submit the ONCC Testing Accommodations Request Form within five days of applying to test. Incomplete forms will not be accepted. Candidates should ensure the completeness of the form prior to submitting to ONCC.
2. Additional documentation may be requested to support the request for testing accommodations. You are responsible for obtaining any additional documentation requested by ONCC.
3. All documentation submitted in support of a request for testing accommodations, including this form, will be kept confidential.
4. After your test application and accommodations are approved, ONCC will send you an email with a link to an additional form that must be completed and submitted to PSI (the test delivery vendor) to ensure the appropriate accommodations are provided. You should wait until you receive your ATT to complete and submit the form to PSI.
5. PSI will contact you to schedule your testing appointment based on the information you provided on the PSI form. When your appointment has been scheduled, PSI will send you an email confirmation.
6. Test results reports will contain no indication that a test was taken with a testing accommodation.
7. All ONCC tests and assessments are administered by computer-based testing. There is NO paper and pencil test available.
8. Questions should be directed to ONCC (via email or by telephone 877-769-6622).

### SECTION ONE: TO BE COMPLETED BY THE CANDIDATE REQUESTING TESTING ACCOMMODATIONS

Last Name	First Name	Middle Initial				
Home Address						
City	State	Zip Code				
Home/Cell Phone Number	Email Address					
Test:	OCN®	AOCNP®	CBCN®	CPHON®	TCTCN™	ROCN™

This is a two page form. You must have Section Two (next page) completed by a qualified healthcare provider. You must submit both pages of this form for your testing accommodations request to be considered.



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### SECTION TWO: TO BE COMPLETED BY A QUALIFIED HEALTHCARE PROVIDER

*The professional evaluation must have been made by a licensed individual who is qualified to diagnose the specific disability, and been made no earlier than three years prior to application.*

Specific Disability/Disabilities: \_\_\_\_\_

Treatment/Medication History: \_\_\_\_\_

Date of Initial Evaluation and Treatment: \_\_\_\_\_ Date of most Recent Evaluation: \_\_\_\_\_

Current Treatment/Medication Status: \_\_\_\_\_

List the specific diagnosis tests performed and conclusion based on diagnostic tests: \_\_\_\_\_  
\_\_\_\_\_

Describe the functional limitations resulting from the disability: \_\_\_\_\_  
\_\_\_\_\_

Describe accommodations that have been provided in the past: \_\_\_\_\_  
\_\_\_\_\_

Specific recommended accommodation(s) for the certification test (check all that apply):

Special seating or other physical accommodation: \_\_\_\_\_

Extended testing time (indicate whether 1.5 hours or 3 hours of additional time is required): \_\_\_\_\_

Separate testing room: \_\_\_\_\_

Other, please describe: \_\_\_\_\_

Professional's Name: \_\_\_\_\_ Credentials: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Professional License Number: \_\_\_\_\_ State of Licensure: \_\_\_\_\_

Specialty certification/qualifications: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_