Health & Wellness Coach Certifying Examination
Test Accommodations

Overview and Instructions

To Request Test Accommodations

1. Carefully read these instructions, the *General Guidelines* and the specific guidelines that pertain to the reason for your request.

2. Complete each section of the Request for Test Accommodations Form as instructed; sign and date the form.

3. Gather the required supporting documentation of the disability and your need for accommodation.
   - Compare your documentation with the information provided in the guidelines to ensure a complete submission. Incomplete documentation may delay processing of your request.

4. Submit your request and supporting documentation.
   - Create/go to your candidate account at www.MyNBME.org
   - Complete your exam registration
   - Indicate that you intend to request test accommodation by checking the box and creating your Accommodtions Request Case

5. Upload your completed request form and supporting documents to your Accommodations Request Case at www.MyNBME.org
   - Documents must be in the form of portable document files (pdf)
   - Maximum allowed file size is **2GB** per file uploaded
   - **Do not** include embedded web links to source documents

6. NBME Disability Services will acknowledge receipt of your request by email within a few business days of receiving your uploaded request for test accommodations. If you do not receive an acknowledgement within that timeframe, please contact Disability Services directly.

Contact Information

Direct questions about test accommodations to:

Disability Services
National Board of Medical Examiners
3750 Market Street
Philadelphia, PA 19104-3102
Telephone: 215-590-9700
Fax: 215-590-9422
Email: disabilityservices@nbme.org

Introduction

Reasonable and appropriate accommodations are provided in accordance with the Americans with Disabilities Act (ADA) for individuals with documented disabilities. The purpose of test accommodations is to provide access to the examination program. While presumably the use of accommodations will enable the individual to better demonstrate his/her knowledge or skill, accommodations are not a guarantee of improved performance, test completion, or a particular outcome.

The ADA defines disability as a physical or mental impairment that substantially limits one or more major life activities as compared to most people in the general population. Examples of major life activities include, but are not limited to, walking, seeing, hearing, and learning.

Determination of whether an individual is substantially limited in functioning as compared to most people is based on an individualized assessment of the current impact of the identified impairment. Supporting documentation is necessary to determine what, if any, accommodations are appropriate for the disabled individual in the examination setting and context. It is essential that supporting documentation provide a clear description of the functional impairment and a rationale for the requested accommodation that is relevant to the setting and context of the specific examination.

The following information is provided for examinees/candidates, evaluators, and others involved in the process of documenting a request for accommodations. Individuals requesting accommodations are welcome to share these guidelines with their evaluator, treating professional, and others so that appropriate documentation can be assembled to support the request.

Confidentiality

All submitted disability related documentation is considered personal and confidential and is securely maintained. Access to such information is limited to those individuals responsible for processing and reviewing the documentation for the purpose of determining eligibility for test accommodations, including a professional review by experts in the appropriate area of disability. No information concerning a request for accommodations is released to a third party without a written request or consent from the individual, subject to any legal requirements to provide documents that NBME may have in its custody or control, and to the possible need to disclose such information to attorneys or other third parties in the event of any disputes relating to an accommodation decision.

Guidelines to Request Test Accommodations

The following general guidelines are applicable to all disabilities and are provided to assist you in documenting a need for test accommodations based on an impairment that substantially limits one or more major life activities. Additional guidelines for documenting certain specific disabilities are also provided below.

General Guidelines

Requests for accommodations must include the following:

1. **A completed and signed *Request for Test Accommodations* form**
   - Instructions and forms for requesting test accommodations are available at the examination program's webpage. Follow the instructions on the appropriate form to initiate a request for accommodations. Requests made by a third party (e.g., evaluator, school, or employer) will not be accepted.

2. **A personal statement**
   - Provide a written statement describing the disability for which you are requesting accommodations.
     - Include specific information about the disability-related symptoms and how they affect your academic, occupational, social and other important areas of functioning.
     - Describe the extent to which your daily functioning is impaired and how that impairment interferes with your ability to access the examination under standard conditions.
     - Provide a clear rationale for the requested accommodation(s) and describe how each requested accommodation will alleviate the functional limitations caused by your disability.

3. **A report of professional evaluation and/or appropriate records from a qualified evaluator/treating professional**
   - Documentation from the evaluating or treating professional should be comprehensive and provide specific evidence of impairment.
   - In most cases, the professional evaluation should have been conducted within the past **three years**. More recent documentation may be necessary for relapsing-remitting conditions or conditions that can change as a result of time or treatment (e.g., visual, neuromuscular, psychiatric impairments).
   - The evaluating professional should have training and direct experience in the diagnosis and treatment of adults in the specific area of disability.

- The diagnostic methods used should be appropriate to the specific disability and current professional practices within the field. The evaluation report should adhere to current professional standards.

- The qualified professional should provide their full name, professional credentials, current title, mailing address, e-mail address, and telephone number.

- A comprehensive report of evaluation should include:
  - a description of the onset, frequency, intensity, and duration of relevant symptoms as well as the extent to which the symptoms impact your daily functioning across multiple environments (e.g., social, academic, occupational, etc.);
  - a statement of the presenting problem and background history;
  - a description of the assessment procedure as well as specific diagnostic tests administered;
  - a detailed analysis and interpretation of the findings;
  - actual results (e.g., scores) of all diagnostic procedures and tests utilized in the evaluation;
  - if a diagnosis is indicated, the evaluator should describe a professionally recognized diagnosis based on criteria outlined in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the *International Statistical Classification of Diseases and Related Health Problems (ICD);*
  - a description of the full extent of the individual's functional limitations due to the disability and how it impacts the individual's access to the examination under standard testing conditions;
  - a description of the functional impact on physical, perceptual, and cognitive abilities in the context of the specific examination setting and format (e.g., computer-based examination; clinical or performance-based examination) compared to most people in the general population;
  - a clear rationale for the recommend accommodations and/or assistive devices.

- Informal or non-standardized assessment methods, if used, should be described in enough detail that other professionals in the field can understand their significance in the diagnostic process.

- If there is no prior history of accommodations, the qualified professional should describe why accommodations have not been required or provided in the past and why they are needed for this examination.

4. Relevant objective records of impaired functioning

- Objective records of functioning should be submitted to document the real-world current impact of the disability and demonstrate how a major life activity relevant to the setting and context of the specific examination is substantially limited.

- Examples of supporting documentation include but are not limited to:
  - Prior clinical evaluations, diagnostic reports, treatment and/or educational plans, or other relevant medical records.
  - Written feedback from teachers or supervisors.
  - Official academic records and transcripts.
  - Official score reports for nationally normed standardized tests (e.g., SAT, ACT, MCAT, LSAT, GRE, GMAT, professional licensing or certifying exams, etc.).
  - Performance evaluations from training programs, military service, or employment settings (e.g., part-time/full-time volunteer/paid jobs, clerkship/internship/residency, etc.).
  - Official records verifying approved accommodations from schools or other testing agencies listing the specific accommodations approved and dates that they were provided.

ALL Supporting documentation must be clear, legible and complete

- Ensure that the documents you send are legible, particularly when submitted in electronic form (e.g., PDF files must be easily readable).

- Reports and correspondence from professionals must be typewritten on official letterhead, dated, and signed by the professional. Handwritten or unsigned letters from physicians or evaluators will not be accepted.

- Provide certified English translations of non-English documentation.

- **DO NOT SEND ORIGINAL DOCUMENTS:** Send complete copies of original documents. NBME will not return originals.

- **DO NOT SEND MULTIPLE COPIES OF DOCUMENTATION** (e.g., email *and* mail copies of the same documents)

- **DO** ensure that reports, transcripts, or other multipage documents are submitted with all pages intact.

Supplemental Documentation

Upon receipt, your submission will be audited for completeness. You will be notified in writing if the documentation submitted in support of your request is insufficient for us to make an informed decision and you will be offered the opportunity to supplement your request and supporting documentation.

Reconsideration

When our review is complete, you will be notified in writing of the decision. Individuals may request that NBME reconsider its decision regarding test accommodations by submitting a signed and dated letter requesting reconsideration accompanied by new substantive supporting documentation.

Documentation Guidelines for Certain Disabilities

Specific Learning Disorder

In addition to the information described in the *General Guidelines*, a request for test accommodations on the basis of a Specific Learning Disorder should include the following:

1. A report of evaluation by a qualified professional

- A comprehensive psychological, psycho-educational, or neuropsychological evaluation that adheres to current professional standards. It is up to each evaluator to determine an appropriate assessment battery for any given evaluation.

- The report of evaluation should generally include the following:
  - Relevant aspects of the individual's developmental, family, medical, and other history including linguistic history, if English is not the first language.
  - A summary of the individual's educational history, experiences, and achievements, quality of instruction, and language of instruction at each level, and trends in academic performance.
  - History of prior academic interventions and classroom or test accommodations.
  - A review of documentation from third-party sources when available (e.g., academic records; scores from prior standardized exams; previous evaluations; feedback from teachers/faculty, tutors, academic advisors, or others; etc.).
  - Data and information from a comprehensive battery of standardized, norm-referenced tests and measures used to assess the individual's cognitive and academic functioning.
    - The *Nelson-Denny Reading Test (NDRT)* and *Wide Range Achievement Test (WRAT)* are *not* comprehensive diagnostic measures of achievement and therefore neither is considered acceptable if used as the sole measure of reading ability or academic skills.
  - Actual scores obtained for each subtest and/or measure administered reported as age-based standard scores when available from the test publisher.
  - The specific version of each test (e.g., 4th Edition, etc.) along with the specific norms used for scoring (e.g., age-based norms).
  - A summary integrating the obtained test and assessment data with relevant background/historical information, previous and current manifestations of the learning impairment, and current academic, occupational, and other life functioning.

- A differential diagnosis with discussion of how each possible alternative explanation for the learning difficulty has been systematically ruled out (e.g., inadequate match between the individual's ability and instructional demands; cultural or linguistic factors; poor motivation and/or study skills; problems of attention, mood, or anxiety; sensory impairments; etc.)

- An explanation of how the specific area of impairment is relevant to the examination setting and context and how the standard conditions present a barrier to the individual's access the examination.

- A rationale for each recommended test accommodation.

- If no prior history of classroom or test accommodations, an explanation of why accommodations have not been required/provided in the past and why they are necessary at this time in the context of the specific examination.

2. Objective records of impaired functioning

- While historical records of childhood learning difficulties may not be obtainable in every case, providing objective documentation demonstrating a history of academic impairment (e.g., reading, writing) is useful to demonstrate the developmental nature and course of the impairment(s).

- Objective records that reflect current/recent academic, occupational, or other functional impairment that demonstrate how a major life activity is substantially limited relevant to test taking. Refer to the *General Guidelines* for examples of supporting documentation.

Attention-Deficit/Hyperactivity Disorder (ADHD)

In addition to the information described in the *General Guidelines*, a request for test accommodations on the basis of ADHD should include the following:

1. A report of evaluation by a qualified professional

- It is up to each professional to determine an appropriate assessment battery for any given evaluation.

- The professional report should generally include the following:
  - Relevant aspects of the individual's developmental, educational, family, medical, psychosocial, educational, occupational, and other personal history.

  - A history of the individual's presenting symptoms, with detailed information about how the symptoms have manifested in the home, school, work, and other settings over time.

  - Self-report symptom checklists, behavior rating scales, and continuous performance tests may be useful in diagnosing ADHD. Since adult recall of childhood symptoms tends to be unreliable, the evaluator should seek ancillary information from other sources (e.g., parent, teacher, spouse) as well as examples of current functional impairment in more than one setting.

  - A review of documentation from third-party sources, when available, to establish a history of impairment that goes beyond self-report (e.g., review of academic records; scores from prior standardized exams; previous evaluations or treatment records; feedback from teachers/faculty, advisors, supervisors; etc.).

  - A differential diagnosis with a discussion of how each possible alternative explanation for the identified problem(s) has been systematically ruled out.

  - A rationale for each recommended test accommodation.

  - If the report includes a comprehensive psychological, psycho-educational, or neuropsychological evaluation, it should adhere to current professional standards and include:
    - Actual scores obtained for each administered subtest and/or measure reported as age-based standard scores when available from the test publisher.

    - The specific version of each test (e.g., 4th Edition, etc.) along with the specific norms used for scoring (e.g., age-based norms).

- A summary integrating all obtained test and assessment data with available clinical presentation, behavioral observations, relevant background/historical information, and current functioning to support the diagnostic conclusion.

- If no prior history of classroom or test accommodations, an explanation of why accommodations have not been required/provided in the past and why they are necessary at this time for this specific examination.

2. Objective records of impaired functioning

- While historical records of childhood difficulties may not be obtainable in every case, providing objective documentation demonstrating a history of functional impairment in more than one setting is useful to demonstrate the developmental nature and course of the impairment(s) due to ADHD.

- Records of current/recent real-world functional impairment in academic, social, and/or vocational settings and in daily adaptive functioning demonstrating how a major life activity is substantially limited.

Visual Impairments

In addition to the information described in the *General Guidelines*, a request for test accommodations on the basis of a visual impairment should include the following:

1. A report of evaluation by a qualified vision professional

- Include a detailed discussion of how the specific symptoms and assessment results meet professionally recognized diagnostic criteria for the identified visual impairment.

- Include relevant history and course of the presenting symptoms and whether the condition is stable or could be expected to change over time.

- Where relevant to the diagnosis and the examination for which accommodations are requested, comprehensive documentation should include detailed information about the health of the eye(s), visual fields, binocular functioning, accommodative functioning, oculomotor functioning, and other pertinent information. Examples of such data include:
  - visual acuities (best-corrected for near and distance);
  - visual field print-outs;
  - specific tests of accommodation (e.g., relative accommodation, amplitudes, facility, dynamic or nearpoint retinoscopy);
  - specific tests of vergence (e.g., nearpoint of convergence, cover test, prism vergences, facility);
  - specific tests of reading eye movements (e.g., Developmental Eye Movement test, photo-electric oculogram)

- Include actual scores and results from all tests, procedures, measurements, and scales administered to demonstrate the level of impairment to visual functioning.

- Detailed information about what therapy, medication, and low-vision aids are being used to treat the impairment, and the effectiveness of these interventions, including all relevant post-therapy data.

- A specific recommendation for all accommodations requested, including low vision aids, and an explanation of how the accommodations will reduce the impact of the identified functional limitations relevant to the specific examination setting and context.

2. Objective records of impaired functioning

- Include objective records demonstrating how the visual impairment substantially limits functioning relevant to the specific examination for which accommodations are requested.

- Visual impairment in only one eye can often significantly impact the ability to perform three-dimensional tasks. However, monocular conditions, in and of themselves, have not been shown to cause a substantial limitation in the ability to read or perform other two-dimensional tasks at near. Therefore, requests for accommodations for computer-based tests based on visual impairment in only one eye need to provide data to demonstrate reduced functioning in the fellow eye, such as accommodation (focusing) or reading eye movements (saccades).

Hearing Impairments

In addition to the information described in the *General Guidelines*, a request for test accommodations on the basis of hearing impairment should include the following:

1. **A report of evaluation by a qualified professional (e.g., audiologist, otolaryngologist)**
   - Actual scores and results from all tests, procedures, measurements, and scales administered.
   - Information concerning the current impact of the hearing impairment on the individual's daily life functioning.
   - A statement about whether the hearing loss is static or changing and how the impairment is expected to impact the individual's ability to access the examination.
   - Detailed information about what therapy, assistive devices, or communication strategies are being used to treat or ameliorate the impairment, and the effectiveness of these interventions.
   - A rationale for each recommended test accommodation relevant to the specific examination setting and context (e.g., for computer-based vs. clinical skills examinations).
2. **Objective records of impaired functioning**
   - A copy of the most recent audiogram or audiometric study that was conducted. Documentation should ideally reflect the examinee's audiologic functioning **within the past year**. Older documentation may be sufficient for a hearing loss that is considered static in nature. Recent documentation (e.g., within the past 6 months) may be needed for hearing impairments that are variable in course and expected to change over time.

Assistive devices

- **Hearing aids and cochlear implants** without Bluetooth/wireless capability enabled are considered pre-approved personal items and are permitted in the secure testing facilities upon inspection by the test center staff. Individuals do not need to request permission to use these personal amplification devices, but should be prepared to show the item(s) to test center staff when checking in for their examination.

Psychiatric Disorders

In addition to the information described in the *General Guidelines*, a request for test accommodations on the basis of a psychiatric disorder should include the following:

1. A report of evaluation by a qualified professional

- A comprehensive psychiatric or psychological evaluation should adhere to current professional standards (e.g., the current version of the American Psychiatric Association's Practice Guidelines for the Psychiatric Evaluation of Adults) and should include the following:
  - A description of the presenting problem(s) and symptoms, with details about the onset and history of symptoms, as well as their current frequency, severity, and duration, etc.
  - Information about the individual's current daily life activities (e.g., school, working, home, social, etc.) and day-to-day functioning relative to most people.
  - Relevant aspects of the individual's history, with details regarding any past or present impact of psychiatric symptoms on academic, occupational, and social functioning.
  - It is up to each evaluator to determine an appropriate assessment battery for any given evaluation. Provide assessment data and findings from all diagnostic tests and measures administered. Examples of common tests and measures include:
    - Structured diagnostic interviews/clinical interviews (e.g., *Structured Clinical Interview for DSM-5 (SCID-5)*).
    - Standardized norm-referenced measures of cognitive or neuropsychological functioning.
    - Behavior or symptom rating scales (e.g., current versions of the *Yale-Brown Obsessive Compulsive Scale (Y-BOCS), Beck Depression Inventory (BDI), Multiscore Depression Inventory for Adolescents and Adults (MDI), Beck Anxiety Inventory (BAI), Depression Anxiety and Stress Scales 21, Minnesota Multiphasic Personality Inventory (MMPI), Conners' Adult Rating Scale, Achenbach Adult Self Report for Ages 18-59, Achenbach Behavior Checklist for Ages 18-59, Clinical Assessment of Depression, Test Anxiety Inventory,* or other scales for anxiety, mood, trauma, or related symptoms).

  - Rating scales and other diagnostic instruments are not meant to be used in isolation; no one measure is considered sufficient by itself to make a psychiatric diagnosis.

- Symptom severity indices.

- Objective tests of effort (e.g., symptom validity tests).

- A thorough summary that integrates test and assessment data with clinical presentation, behavioral observations, relevant background/historical information, and current functioning.

- Evidence of a differential diagnosis and a description of how each possible alternative explanation for the identified problem has been systematically ruled out.
  - For example, symptoms of the diagnosed psychiatric disorder must be distinguished from normal adult reactions and behaviors such as test anxiety, academic underachievement or failure, bereavement, personality traits, or low self-esteem.

- A specific diagnosis based on criteria for psychiatric disorders consistent with the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the *International Statistical Classification of Diseases and related Health Problems (ICD)*.

- A clear description of how the identified impairment and related symptoms are relevant to the specific examination setting and context.

- A rationale for each recommended test accommodation.

2. Objective records of impaired functioning

- Records that reflect the individual's functioning in daily life activities (e.g., social, academic, occupational environments, etc.) since the onset of the psychiatric disorder and at the present time.

- A report of evaluation or treatment summary completed **within the past six (6) months** is necessary to establish the extent of current impairment and need for accommodations at the present time.

Personal Item Exceptions (PIEs)

The personal items listed below are permitted in the secure testing area subject to inspection by test center staff. If you have a medical need for one or more of these items during your examination, you do NOT need to make a request or submit documentation to NBME for approval. Please show the item to test center staff when you check in for your examination.

Medicine and Medical Devices

Arm/shoulder sling
Bandages
Braces – neck, back, wrist, leg, or ankle
Casts/cervical collar
Cough drops (must be unwrapped and not in a bottle/container)
Earplugs (foam with no strings) Step 1, Step 2 CK, and Step 3 only
Epi-Pen
Eye drops
Eye patches
Eyeglasses (without the case)
Glucose monitor
Glucose tablets
Handheld magnifying glass (non-electric, no case)
Ice packs/heating pads
Inhaler
Medical alert bracelet
Nitroglycerin tablets
Pillow/lumbar support
Pills (must be unwrapped and not in a bottle/container)
Stool for elevating a limb
Surgical face mask Step 1, Step 2 CK, and Step 3 only
Walking boot casts

Medical Device Attached to a Person's Body

Catheter
Colostomy bag
Heart rate monitor
Insulin pump
Oxygen tank
Spinal cord stimulator
TENS units
Urine drainage bag

Communication Aids

Hearing aid/cochlear implant without Bluetooth/wireless capability

Vocal cord magnifiers
Mobility Devices
Cane
Crutches
Walker
Wheelchair

If you have a medical condition that requires use of an item NOT on the above list, contact the NBME at disabilityservices@nbme.org or 215-590-9700 for additional information on how to request a personal item exception.