American Occupational Therapy Association

aota.org

Request for Accommodations
CANDIDATE FORM

To request an examination accommodation for a disability, please upload this form as part of your application. AOTA must receive your Candidate Form and Provider Form (and related required evaluation of your disability and the appropriate accommodation) completed by a physician or other health care provider or relevant authority.

The provider's documentation should identify (i) the diagnosis and nature of your disability, (ii) the last time the provider saw you and the diagnosis of the disability, (iii) the name of the test used, (iv) the length of time that you've had the condition, and (v) what accommodation is suggested to accommodate the disability.

Name:

Address:

Email Address:

Phone Number:

Description of Disability:

Requested Accommodation:

Previous Accommodation (if any):

I understand that AOTA will use the information obtained by this authorization to determine eligibility for a reasonable accommodation in regard to this examination by reason of my disability. Under penalty 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 revocation of certification. I hereby certify that I personally completed this portion and that I may be asked to verify the above information at any time.

Signature:

Date:

Please note that the PROVIDER FORM, in addition to the letterhead evaluation from the provider, must be completed by a physician or licensed health care provider appropriate to the disability.

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