



AOBFP

REQUEST FOR ACCOMMODATION

APPLICATION

REVISED 5/09

AOBFP
REQUEST FOR
ACCOMMODATION APPLICATION

INSTRUCTIONS:

1. Please read all of the following information
2. Complete the Candidate Questionnaire
3. Obtain documentation from the qualified professional(s) who assessed your disability no earlier than two years prior to this application for test accommodation.
4. Submit completed questionnaire and all supporting documentation along with the examination application, required application materials and exam fee to the AOBFP by the INITIAL established post office postmark deadline date for examination administration applied for. Applications received postmarked after the initial deadline date will be held pending a future examination. The initial postmark deadline date can be found on the front of the examination application or on the AOBFP website at www.aobfp.org.
5. It is recommended that:
 - a. the candidate retains a photocopy of the questionnaire and all documentation submitted
 - b. the questionnaire and all documentation be sent via a traceable or return-receipt method in order to ensure timely delivery to the AOBFP office

ELIGIBILITY

The American Osteopathic Board of Family Physicians (AOBFP) is in compliance with the Americans with Disabilities Act (ADA) of 1992. If a candidate has a disability and requests an accommodation(s) in taking an AOBFP examination, the candidate must make application to the AOBFP for consideration of that accommodation by submitting the required questionnaire and documentation.

CANCELLATION

The AOBFP requests that a candidate who needs to cancel his/her registration for the examination contact the AOBFP at least two weeks prior to the exam administration date. In the event of a cancellation, the candidate will incur a rescheduling fee or the withholding of a portion of the exam fee if a refund is requested, and indemnify the AOBFP for any costs incurred in connection with the request for accommodation.

CANDIDATE QUESTIONNAIRE

AMERICAN OSTEOPATHIC BOARD OF FAMILY PHYSICIANS

Instructions:

1. The application and all documentation **MUST BE TYPED OR PRINTED**. Illegible materials will not be considered.
2. Complete the entire application.
3. Submit this form, along with your examination application, exam fee and supporting documentation by the established INITIAL post office postmark deadline date.
4. Forward to: AOBFP, 330 E. Algonquin Road, Suite #6, Arlington Heights, Illinois, 60005
5. It is recommended that all documentation be submitted via traceable or return-receipt method in order to ensure timely delivery

AOA No. _____



Name: _____

Address: _____

Phone No. (Day) _____ Evening No. _____

E-MAIL ADDRESS _____

The disability with which I have been diagnosed: _____

The examination administration date for which I request accommodations(s):

The accommodation(s) I request for the above administration s/are: _____

I have requested an accommodation(s) in a similar testing situation: ____ Yes ____ No

If yes, then please complete the following as it applies to you:

Osteopathic College:

School: _____

*Accommodation(s) received: _____

*Standardized examinations:(e.g. MCAT, SAT, GRE, etc.)

Exam: _____ Date(s): _____

Exam: _____ Date(s): _____

*Accommodation(s) received: _____

*Attach a separate page if necessary

Other Schools:

College: _____

Accommodation(s) received: _____

Secondary school and/or elementary school: _____

Accommodation(s) received: _____

****Note:** An individual who has received an accommodation(s) in the past should provide documentation of each accommodation(s).

I, as an applicant for accommodation(s), agree to the conditions of this application as stated by the AOBFP. I hereby authorize any person, company, facility or office which has provided information or documentation in support of my request for accommodation(s) to consult with, to make written reports to, and to release information including, but not limited to, medical and/or testing records, to representatives of the AOBFP and/or its consultants.

I release the AOBFP's consultants and individuals and entities that submitted information concerning my disability from any and all liability in connection with their providing information to the AOBFP including, without limitation, liability under HIPAA or any other state or federal law in connection with their release of information.

By signing this statement, I declare, under penalties of perjury, that all of the information and documentation I am providing is true, accurate and complete.

Signature: _____ Date: _____