

**DEPARTMENT OF HEALTH  
OFFICE OF HEALTH PROFESSIONS  
BOARD OF DENTURISTS  
POLICY/PROCEDURE**

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**Title:** Disability Accommodations for Examination      **Number:** DN 01

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**Reference:** American with Disabilities Act (ADA)

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**Contact:** Trina Crawford, Executive Director

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**Effective Date:** April 2011

**Re-Approval Date:** April 26, 2018

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**Approved:** Signature on file

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J. Eric Hansen, Chair, Board of Denturists

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**PURPOSE STATEMENT:**

The purpose of this policy is to provide guidelines for the evaluation and granting of requests for reasonable accommodations in the administration of the Washington State Denturist written and/or clinical examinations to qualified applicants.

**POLICY STATEMENT:**

The Washington State Board of Denturists (board) will grant reasonable and appropriate testing accommodations to individuals with qualifying disabilities that register for the Denturist written and/or clinical examinations. All requests for accommodations will be considered on a case-by-case basis.

**APPLICANT'S RESPONSIBILITIES:**

The applicant has the responsibility of submitting current information in a timely manner before the scheduled examination date. The required documentation shall include a diagnosis of the specific disability by a professional qualified to assess and diagnose the asserted disability. The documentation must include:

- A current, valid, professionally recognized diagnosis of the candidate's disability (e.g. pursuant to the International Statistical Classification of Diseases and Related Health Problems (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM IV: revised)) by an appropriately qualified expert with copies of and reported scores from professionally recognized diagnostic tests, where applicable.
- Documentation that clearly identifies the nature and extent of the functional limitations that exist as a result of the diagnosed disability.
- Specific information about the significance of the impact the disability has on the candidate in the testing environment.
- A history of any accommodations previously granted in any educational program or examination.
- Specific recommendations for accommodations.
- An explanation of why each accommodation is recommended and why it is necessary to alleviate the impact of the disability in taking the written and/or clinical examination.

The Board reserves the right to request additional information at any time from the candidate requesting accommodations on its examinations.

**PROCEDURE TO REQUEST AN ACCOMMODATION:**

1. The applicant must submit the required documentation with the licensure application prior to the approval of the applicant to sit for the denturist written and/or clinical examination. The required documentation includes a completed Applicant Special Accommodations Request Form, Professional Documentation of Disability Form, Professional Documentation of Disability Form and School ADA Accommodation History Form. These forms will be provided by the Board to an applicant upon request. The applicant is not precluded from providing any additional documentation. The cost of providing the required documentation is the applicant's responsibility.
2. Receipt of the licensure application and required documentation will be acknowledged by the Board. If the applicant's documentation is incomplete or insufficient, notice will be given to the applicant by the Board.

The Board will review the request only after receiving all of the required documentation. Processing and decision-making on a completed application is expected to take three (3) weeks. Each request will be considered on its own merit relative to the documentation received regarding the disability.

If the applicant has more than one disability for which he/she is seeking accommodation, separate documentation is required for each disability.

## **QUALIFIED APPLICANTS:**

The ADA defines an individual with a disability as a person who has a physical or mental impairment that substantially limits that person in one or more major life activities, has a record of such impairment, or is regarded as having such impairment. “Major life activities” include functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Disability under the Washington Law Against Discrimination (WLAD) means the presence of a sensory, mental, or physical impairment that is medically cognizable or diagnosable; exists as a record or history; or is perceived to exist. A disability exists whether it is temporary or permanent, common or uncommon, mitigated or unmitigated, or whether or not it limits the ability to work generally or work at a particular job or whether or not it limits any other activity within the scope of WLAD.

A “qualified” individual with a disability is one who meets the statutory and regulatory requirements to sit for the examination and with or without reasonable accommodation, can perform the essential functions of a dentist.

**Reasonable Accommodation** means a modification in the examination administration that does not fundamentally alter the requirements for licensure or the measurement of the knowledge, skills and abilities, the examination is designed to test or that does not impose an undue hardship.

### **Confidentiality of Required Documentation**

The Board shall maintain confidentiality of health care information obtained through the accommodation process to the extent the law allows and conditioned upon the Public Records Act, RCW 42.56. Further dissemination may be made to Board staff or an independent expert hired by the Board to assist in evaluating the application as needed to ensure effective management of the reasonable accommodation process. Retention and destruction of the documents will be made pursuant to the Department of Health’s Record Retention Policy.

## **BOARD DECISION MAKING PROCESS:**

Applications will be reviewed to determine whether the applicant is a Qualified Applicant and, if so, whether the modification is a Reasonable Accommodation. The Board recognizes that it must provide thorough yet expeditious review and decisions upon receipt of completed requests for examination accommodations. For purposes of such reviews, one Board member will coordinate with the program manager to ensure that any request or appeal is complete and to communicate with the applicant in a timely manner regarding any incomplete request or appeal and what the applicant must do to complete the request or appeal.

Completed requests, will be presented to a Board panel for consideration.

Once the applicant is determined to meet the definition of a Qualified Applicant, then the requested accommodation will be considered in terms of whether the accommodation:

- Will fundamentally alter the knowledge, skills and abilities the examination is designed to measure,
- Is appropriate to the identified need, and
- Is within the parameters of the both the ADA and WLAD's requirements

In addition, \*an accommodation may not be reasonable if it causes the Board undue hardship. Undue hardship means an action requiring significant difficulty or expense. When determining reasonableness, the Board will consider the following:

- The nature and cost of the accommodation,
- The impact of the accommodation on operations of the testing center,
- The overall financial resources of the Board, and
- The availability of alternative accommodations that would not impose such hardship.

Examples of accommodations that could be provided include:

- One and half times the standard time given
- Double the standard time given
- Zoom Text (software that enlarges print on the computer screen)
- Screen magnifier
- Separate room
- Reader
- Scribe

If a candidate requests a reasonable accommodation that is not included in the standard list, the Board may work with the Department of Health to accommodate the individual. Some examples of other accommodations that may be provided are: Colored overlays, magnifiers for paper exams, and ear plugs.

The Board's decision on a request or an appeal will be communicated in writing to the applicant at the address used by the applicant on the applicable form or document. The Board's written decision will identify any relevant facts, its conclusions, and its decision. If independent expert opinion is used, the decision will reflect the source of such independent expert opinion. Any decision on a request that does not grant a specific accommodation as requested by the applicant will identify for the applicant his or her rights to appeal and the appeal process as described herein. If the modification granted is not listed among those provided on the Applicant Special Accommodations Request Form, the decision to grant the accommodations will be subject to final approval by the board. The applicant will be informed of this final condition.

### **APPEAL PROCESS**

An applicant whose request for accommodation is denied in whole or in part may request an adjudicative proceeding consistent with WAC 246-11. The request must include:

- (a) Applicant's name and address;
- (b) Date of request;

- (c) The response to the denial;
- (d) The grounds for the appeal and,
- (e) The applicant's signature.

The request may be accompanied by any further documentation and/or explanation not previously provided which the applicant wishes the board to consider in making a decision on the applicant's appeal. The appeal must be postmarked no later than twenty (20) days after the applicant is served with the denial. The written decision of denial will describe how an appeal may be requested and will be accompanied by a request form. The Board will issue a written decision on any timely appeal within thirty (30) days of receipt. The Board's decision will be mailed to the applicant to the address listed in the appeal.

## Applicant Special Accommodations Request Form

Name: \_\_\_\_\_  
Last First Middle

Current Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

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

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender (circle one): Male Female

### Information About Your Disability and Requested Accommodations

**Describe the nature of your disability? *Please indicate the specific diagnosis.***

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**How does your disability affect your daily life?**

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**How does your disability affect your ability to take the examination?**

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**What accommodation are you requesting during the examination?**

- |                                                       |                            |
|-------------------------------------------------------|----------------------------|
| _____ <b>Additional Time - Time and a half</b>        | _____ <b>Reader</b>        |
| _____ <b>Additional Time - Double Time</b>            | _____ <b>Scribe</b>        |
| _____ <b>Paper and Pencil Exam</b>                    | _____ <b>Separate Room</b> |
| _____ <b>LARGE PRINT Paper and Pencil Exam Reader</b> | _____ <b>Other</b>         |

**What accommodations have you received in the past for the following exams?**

Denturist School Exams \_\_\_\_\_

Undergraduate College Exams \_\_\_\_\_

Standardized Exams (e.g. SAT, GRE, etc.) \_\_\_\_\_

**Documentation Requirements**

Please provide a comprehensive and current report (no more than three years old) from a professional qualified for evaluating your disability. The report must include the following:

- Name, title, credentials and area of specialization of the professional making the diagnosis and accommodation recommendation.
- A diagnosis of the disability pursuant to the International Statistical Classification of Diseases and Related Health Problems (ICD), the Diagnostic and Statistical Manual of Mental Disorders (DSM IV: revised) or other applicable and recognized professional standard with copies of all evaluations and reported scores from professionally recognized diagnostic tests, where applicable.
- Recommendation for specific accommodations.
- Rationale for requesting specific accommodations.

**Candidate Affirmation**

My signature on this form affirms that the information I have provided on this request is true and accurate. I have truthfully represented my disability and the impact it has on my daily life and computerized examinations.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

## Professional Documentation of Disability Form

### Applicant Information

Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_

Exam Type (circle one): Denturist Written Exam      Denturist Clinical Exam

### About the Exam

*The examination for which this candidate is requesting special accommodations consists of objective multiple choice questions which are administered by computer at the Department of Health and a clinical examination.*

*Minimum computer skills are required.*

Exam	Number of Questions	Time Allowed	Unscheduled Breaks
Written	240	4 hours	Restroom breaks can be taken at any time; however, the exam timer will continue to elapse
Clinical		9 hours	Breaks can be taken at any time; however, the exam timer will continue to elapse

### Professional Contact and Background Information

Name: \_\_\_\_\_ Title: \_\_\_\_\_

License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_



Please describe your credentials and experience which qualify you to make this diagnosis and recommendations for testing. You may also attach your Curriculum Vitae (Resume) to show this information.

**Disability and Requested Accommodations**

1. Describe the diagnosed disability and date of diagnosis. Attach all written evaluations supporting the diagnosis, including the scores and interpretive data for all administered diagnosis tests.

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2. Date of your last consultation with the candidate \_\_\_\_\_

3. Please describe: (1) the nature, history, and extent of the disability; (2) how it limits one or more of the candidate’s major life activities; (3) if the disability will change in any way over time. In case of a learning disability, include specifics as to the type of disability (e.g., visual or auditory reception or perception, processing, memory, comprehension, verbal or written expression, etc.)

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4. What effect does the disability have on the candidate's ability to perform on the test as described above?

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5. What are your specific recommendations for accommodations for this candidate? **Please include an explanation of why these accommodations are required.**

- |                                                            |                                        |
|------------------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Additional Time – Time and a half | <input type="checkbox"/> Reader        |
| <input type="checkbox"/> Additional Time – Double Time     | <input type="checkbox"/> Scribe        |
| <input type="checkbox"/> Paper and Pencil Exam             | <input type="checkbox"/> Separate Room |
| <input type="checkbox"/> LARGE PRINT Paper and Pencil Exam | <input type="checkbox"/> Other         |

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I certify that I have the necessary specialized training to make the above diagnosis, that I personally examined the candidate named above, and that the diagnosis and assessment of accommodations requested are based on my professional judgment. I understand that the candidate has authorized me to provide the information on this form, and to provide further information if necessary.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Name (Printed)

## School ADA Accommodation History Form

### Applicant Information

Name:

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Address:

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Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN: \_\_\_\_\_

Phone: \_\_\_\_\_

*The following sections are to be completed by the person responsible for disability services.*

### School Contact Information

Name: \_\_\_\_\_ Title: \_\_\_\_\_

School Name and Address:

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Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### Disability and Accommodations History

1. Specify the type of disability for which the candidate received accommodations (e.g., visual, learning/cognitive, psychological, etc.)

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2. What accommodations were provided to this candidate while he or she was a student at your institution (check all that apply)?

\_\_\_\_\_ Additional Time – Time and a half

\_\_\_\_\_ Reader

\_\_\_\_\_ Additional Time – Double Time

\_\_\_\_\_ Scribe

\_\_\_\_\_ Paper and Pencil Exam

\_\_\_\_\_ Separate Room

\_\_\_\_\_ LARGE PRINT Paper and Pencil Exam

\_\_\_\_\_ Other

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I certify that the information provided by me on this form is true and correct to the best of my knowledge. I understand that the candidate has authorized me to provide the information on this form, and to provide further information if necessary.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Printed)