

## Health & Wellness Coach Certifying Examination Program

### Certification of Prior Test Accommodations

**Please type or print.** To be completed and signed by school official responsible for student disability services.

**Applicant Name:** \_\_\_\_\_ **Candidate ID#:** \_\_\_\_\_

I certify that \_\_\_\_\_ has officially approved and continuously  
Name of School  
provided the following accommodations for the above applicant beginning on \_\_\_\_\_  
Date (Month/Year)

1. Accommodation(s) provided for **classroom and clinical coursework:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for accommodation(s): \_\_\_\_\_

2. Accommodation(s) provided for **written exams:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for accommodation(s): \_\_\_\_\_

3. Accommodation(s) provided for **clinical skills/performance exams:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for accommodation(s): \_\_\_\_\_

Name of School Official: \_\_\_\_\_ Title: \_\_\_\_\_  
Print Name of Official Title of Official

Signature of Official: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

#### Mail, fax, or e-mail completed form to:

Disability Services  
National Board of Medical Examiners  
3750 Market Street  
Philadelphia, PA 19104-3190  
Telephone: (215) 590-9509  
FAX: (215) 590-9422  
E-mail: [dsclients@nbme.org](mailto:dsclients@nbme.org)  
Call or e-mail to verify receipt of Fax and mail submissions