

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: _____ **Registration ID#:** _____

I certify that _____ 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: (____) _____

**Upload completed form to your Accommodations Request Case
at www.MyNBME.org when you register for your exam.**

Disability Services
National Board of Medical Examiners
3750 Market Street
Philadelphia, PA 19104-3190
Telephone: (215) 590-9700
FAX: (215) 590-9422
[E-mail: disabilityservices@nbme.org](mailto:disabilityservices@nbme.org)