Guidelines and Instructions

Application for Disability Accommodations
Disability Accommodation Form (2011)
Program for the Assessment of Veterinary Education Equivalence (PAVE)

The following guidelines are designed to ensure equitable and fair treatment for candidates with documented need for reasonable accommodations in taking the PAVE Qualifying Examination (QE).

Reasonable accommodations are made for candidates whose disabilities will otherwise place them at an unfair disadvantage in the examination. Accommodations are considered only to the extent necessary to give candidates with disabilities a fair and equal opportunity to demonstrate their mastery of skills and attainment of knowledge in the examination.

The Americans with Disabilities Act Amendments Act of 2008 (ADAAA) defines a person with a disability as "any person who (a) have a physical or mental impairment which substantially limits one or more of such person's major life activities, (b) has a record of such impairments, or (c) is regarded as having such an impairment."

Individuals meeting the above definition may be considered disabled and eligible for reasonable accommodations on the QE. A temporary disability (e.g, a broken arm) is not considered a disabling condition under the ADAAA. Nevertheless, candidates having a temporary disability that may hinder their test performance may request a courtesy adjustment for the examination.

The Disability Accommodation Form (2011) is to help the AAVSB and NBVME determine (1) whether you are a qualified disabled individual under federal law and (2) whether the accommodation you are requesting is reasonable. Consideration of all requests will be made under applicable laws, including the Americans with Disabilities Act Amendments Act of 2008.

Part I: The information requested on Part I of the form is self-explanatory. You are not required to furnish your Social Security number, but this information would be most helpful in identifying you and relating Disability Accommodation Form (2011) to other parts of your PAVE application.

Part II: Part II of Disability Accommodation Form (2011) should be completed by your health practitioner or other appropriate professional and signed and dated where indicated.

SUBMISSION OF THE FORMS: The QE is administered by the National Board of Veterinary Medical Examiners (NBVME). This form must be submitted to AAVSB before the NBVME can make arrangements for any examination accommodations requested. Disability Accommodation Form (2011) parts I and II should accompany the PAVE online application.

Candidates requesting accommodations must provide (at their own expense) written documentation that specifies the extent to which routine testing procedures need to be modified to prevent the candidate's disability from interfering with the opportunity to demonstrate their knowledge, skills, or abilities on the QE.

Candidates must provide a report from a physician or other licensed professional health service provider who has diagnosed and/or treated the disability. The report must state a specific diagnosis of the disability; must be current (generally within the past three years); must describe the specific diagnostic criteria and/or diagnostic tests used, including date(s) of evaluation, test results and a detailed interpretation of the test results; must recommend reasonable testing accommodations; and must provide explanations of how and why the recommended accommodations are justified and necessitated by the candidate's disability. If no prior accommodations have been provided, the report should include an explanation as to why no accommodations were given in the past and why accommodations are needed now.

The cover letter from the candidate, the Disability Accommodation Form (2011), and supporting documentation should be provided to the AAVSB office by the posted application deadline date. All submitted documentation will be treated confidentially by AAVSB and NBVME. If you have any questions, please contact the AAVSB office.

A submitted Disability Accommodation Form (2011) will remain valid for one year from the date when executed by the applicant. A valid Disability Accommodation Form (2011) should be considered for any examination occurring within this one-year period provided the candidate makes a request for consideration prior to the examination date. Forms not fully completed will be returned to the applicant.

Under any circumstances, it is recommended that you maintain a copy of this form for your records. Questions may be directed to the AAVSB at 877.698.8482. PLEASE SUBMIT PARTS I AND II OF THE DISABILITY ACCOMMODATION FORM (2011) *AT THE SAME TIME.*

Mail to: AAVSB | 380 West 22nd Street, Suite 101 | Kansas City, MO 64108 | attn: PAVE

Program for the Assessment of Veterinary Education Equivalence (PAVE)
Application for Disability Accommodations

PART I

SSN# ____-___-_____
Optional (see instructions)

Name_____
Last First M.I.

Birth Date ____-____-____

Address_____

_____

Exam Date for which you are applying: ____-____-____

Daytime Phone Number_____

Evening Phone Number_____

Major life activity impaired by disabling condition:_____

Accommodations requested by applicant _____

Physicians or Other Health Care Practitioners:

(a) Name_____

Office Address_____
Street City State Zipcode

Length of time as patient_____

(b) Name_____

Office Address_____
Street City State Zipcode

Length of time as patient_____

Release

I authorize each health care practitioner above to release to the American Association of Veterinary State Boards (AAVSB), or their designated representatives, information which will verify the current functional limitations imposed by my disability which affect my ability to perform under standard testing conditions; and describe the nature of the examination accommodation(s) being proposed and the rationale for those accommodation(s). I further understand that I may be asked to provide additional information about my functional limitation(s) and the requested accommodations and agree to cooperate with reasonable requests for such additional information.

I understand and agree that the information obtained by this authorization will be used solely for the purpose of determining my eligibility for reasonable accommodations in regard to the veterinary licensure process and the nature and extent of the accommodations which are reasonably necessary by reason of my disability. The information obtained by this authorization will not be released or disclosed to any person or organization except the referenced parties, and any other governmental agency that may be involved in acting upon my request for reasonable accommodations in connection with the veterinary licensure process.

I agree that this authorization shall be valid until canceled or revoked in writing by me.

Under penalties 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 loss of a license. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time.

Signature_____ Date_____

Subscribed to and sworn to me before this_____ day of _____, 20____

Notary Public_____

THIS APPLICATION IS VALID FOR A PERIOD OF ONE (1) YEAR FROM THE DATE WHEN FIRST EXECUTED BY THE APPLICANT. (SEE INSTRUCTIONS)

Application for Disability Accommodation
Practitioner's Statement

(A copy of this form must be completed by each health care practitioner providing services to the patient.)

Part II

Practitioner Name_____
Last First M.I.

Office Address_____
Street City State Zipcode

Telephone Number_____

Patient's Name_____

Patient's Address_____
Street City State Zipcode

Patient's SSN#_____-_____-_____

Date patient first seen_____ Date patient last seen_____

1. Diagnosis and description of disabling condition (Please provide any other necessary information including tests administered to determine condition)_____

_____

2. Date of onset_____

3. Major life activity(ies) limited by disabling condition _____

_____

4. Previous accommodations granted and when _____

_____

5. Accommodation(s) requested in this testing situation_____

_____

I hereby certify that the above information is true and is released pursuant to authorization by my patient.

Signature of Heath Care Practitioner _____

Professional Status _____
Physician, Psychologist, etc.

License Number (IF Applicable) _____

Date _____
Month Day Year

For Board Use Only

Board Approval, if applicable: _____ Date _____
Name Title