Request for Accommodations - PROVIDER FORM

Please submit this form and related materials to:

Hand Therapy Certification Commission, Inc.
180 Promenade Circle Suite 300 #41
Sacramento, CA 95834
T: 916-566-1140 F: 916-922-0210

I, _____ (printed name of candidate), hereby authorize and request the provider identified below to release the information requested by HTCC relating to my disability and the accommodation appropriate to my disability to sit for the HTCC examination.

Signed: _____ Date: _____

The candidate/patient identified above is requesting accommodation to sit for the Hand Therapy Certification Commission ("HTCC") examination. HTCC's accommodation policy requires candidates requesting accommodation to submit current documentation of the disability from an individual qualified to assess the disability. The candidate is requesting that you provide such documentation; you should submit your evaluation on your professional letterhead.

Your evaluation should include your assessment of the candidate's disability as well as an accommodation plan. The documentation should explain the type and degree of the candidate's disability and how the proposed accommodation affects the disability.

The documentation should include the following information: (i) the month, day and year the candidate/patient first consulted you; (ii) the month, day and year the candidate/patient was last seen by you; (iii) the diagnosis of the candidate/patient's disability; (iv) the name of the tests used; and (v) the length of the condition.

You are also required to include recommended accommodations for testing in the documentation. Finally, please sign the statement below and include it in the transmittal of your evaluation.

PROVIDER DECLARATION

I hereby certify that the above information is true and is given pursuant to the authorization to release information by my patient. Under penalty of perjury, I declare that the foregoing statements and those in any required accompanying documents or statements are true. I hereby certify that I personally completed this portion and that I may be asked to verify the above information at any time.

Signature _____

Name (please print) _____ Date _____

Address _____

_____

Telephone: (_____) _____ State License #: _____

If you are not licensed, please note credentials that allow you to diagnose the disability:

_____