American Association of Veterinary State Boards

State & Provincial Assessments Application for Accommodations

Overview

The American Association of Veterinary State Boards (AAVSB) is committed to the principle of testing individuals in a manner that will yield valid and reliable examination results. In some instances, the examination administration procedures may need to be modified to provide reasonable accommodations for State & Provincial Assessments (SPA) candidates with disabilities.

The AAVSB Board of Directors reviews and approves all accommodation requests for which the AAVSB determines eligibility on behalf of the jurisdictions. The Accommodations Application provides the necessary information for the AAVSB Board of Directors to determine:

1. whether a SPA candidate is a qualified disabled individual under U.S. or Canadian federal law, and
2. whether the accommodation being requested is reasonable. Consideration of all requests will be made under applicable laws, including the Americans with Disabilities Act Amendment Act of 2008, the Canadian Employment Equity Act, the Canadian Human Rights Code and the Ontario Human Rights Code.

A submitted Accommodations Application will remain on file with the AAVSB. A previously approved accommodations request will be reviewed by the AAVSB Board of Directors for any subsequent examinations provided the candidate makes a request through the state or provincial credential application.

Applications will not be returned to the applicant.

Instructions

SPA Candidates must follow the instructions below to complete the Accommodations Application. Completed Accommodations application and required supporting documents are to be received and at the AAVSB office prior to being included on an eligibility list to the exam vendor. ***Please refer to the AAVSB website for additional details.***

1. **Notify your state or provincial board** you will be requesting accommodations for the SPA examination upon submitting your credential application to the state or provincial board.
2. Complete **Section I** of the Accommodations Application available on the AAVSB website at https://www.aavsb.org/licensure-assistance/jurisprudence-assistance/apply-for-your-jurisdictions-assessment. A Social Security number is not required, but the last four digits will assist in identifying and matching the Accommodation form to the submitted SPA eligibility list received from the state or provincial board
   (Section I is to be mailed directly to the AAVSB. The AAVSB recommends to scan and email Section I to spa@aavsb.org prior to mailing.)
3. Request health care practitioner or other appropriate professional to complete **Section II** of the application. (Section II initially be scanned/emailed to spa@aavsb.org) prior to mailing directly to the AAVSB.
4. **Submit copies of supporting documentation for the accommodations request.** (Documentation can be scanned and emailed by candidate or college to spa@aavsb.org as applicable):
   Diagnostic reports
   IEP
   504 Plan
   College accommodation form

Keep a copy of the completed Accommodations application and supporting documentation for your records.

5. **Mail completed Sections I and II with all supporting documentation to:**

AAVSB
Attn: Exams Team - SPA
12101 W 110th St, Ste 300
Overland Park, KS 66210

For questions, contact the SPA program at spa@aavsb.org or call 1-877-698-8482 during business hours.

Please visit the AAVSB website at www.aavsb.org for SPA application information.

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Section I – To Be Completed by SPA Candidate

Name_____
Last First M.I.

SSN# xxx - xx -_____
Optional (last 4 digits)

Address_____

Birth Date _____-_____-_____

City, State Zip code_____

Specific State or Jurisprudence Exam Administration:
_____

Daytime Phone Number_____
Evening Phone Number_____

Email Address _____

☐Veterinarian
☐Veterinary Technician

Major life activity impaired by disabling condition:
_____

Accommodations requested by SPA Candidate: _____

_____

Name of physician(s) or other health practitioner(s):

(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 take the State & Provincial Assessments (SPA) examination 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 taking the SPA examination as a requirement for state or provincial credentialing.

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_____

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Section II – To be Completed by Physician/Health Care Practitioner

Each physician or health care practitioner providing services to the SPA Candidate should complete one copy of this form.

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#__XXX__-_XX__-_____
Optional (last 4 digits)

Date patient first seen (month/year) _____ Date patient last seen (month/year) _____

1. Diagnosis and description of disabling condition (Please provide any other necessary information including diagnostic codes and 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

***Please include additional supporting documents i.e., Diagnostic reports**