



**NATIONAL CERTIFICATION COMMISSION FOR  
ACUPUNCTURE AND ORIENTAL MEDICINE**

76 S. Laura Street, Suite 1290 Jacksonville, FL 32202

Phone: 904-598-1005 Fax: 904-598-5001

---

**SCHOOL CONFIRMATION OF ADA ACCOMMODATION HISTORY FORM**

---

If you received accommodations during your formal education, please have the appropriate school official complete this form and ensure that it is returned to NCCAOM before the application deadline for your preferred exam date.

*This section to be completed by the candidate.*

**Application deadline for preferred exam date** \_\_\_\_\_

**Candidate name** \_\_\_\_\_

**Address** \_\_\_\_\_

**Date of birth** \_\_\_\_\_

**City, State, Zip, Country** \_\_\_\_\_

**Social Security #** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_

**Name and address of school attended for acupuncture/Oriental medicine education:**

\_\_\_\_\_  
\_\_\_\_\_

*The following sections are to be completed by the person responsible for disability services.*

**SCHOOL DISABILITY PROFESSIONAL'S CONTACT INFORMATION**

**Name** \_\_\_\_\_ **Title** \_\_\_\_\_

**School name and address** \_\_\_\_\_

\_\_\_\_\_

**City, State, Zip,**  
**Country** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_ **E-mail** \_\_\_\_\_

**CANDIDATE'S DISABILITY STATUS**

*Specify type of disability (check all that apply):*

Visual \_\_\_\_\_ Psychological/psychiatric \_\_\_\_\_  
Hearing \_\_\_\_\_ Physical/medical \_\_\_\_\_  
Learning/cognitive disability: \_\_\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_

**ACCOMMODATIONS HISTORY**

The following accommodations were provided to this candidate while he or she was a student at this institution (check all that apply):

Large-print study materials and/or exams _____	Braille materials _____	Reader _____
Dates provided: _____	Dates provided: _____	Dates provided: _____
Audiocassette _____	Scribe/recorder _____	Sign language interpreter _____
Dates provided: _____	Dates provided: _____	Dates provided: _____
Extended testing time (specify how much) _____	Other accommodations provided: _____	
Dates provided: _____	_____	
	Dates provided: _____	

**VERIFICATION**

This institution or its disabilities services office has on file (or had on file at the time the accommodations were provided) documentation or diagnostic data confirming the candidate's disability:

Yes \_\_\_\_\_ No \_\_\_\_\_

**I certify that the information provided by me on this form is true and correct to the best of my knowledge. I agree, if requested by NCCAOM, to send NCCAOM a copy of the file or other documentation pertinent to establishing the need for these accommodations. I understand that the applicant authorized the release of this information as part of the application process for requesting accommodations.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Return this form to the candidate or mail or fax it to:*

NCCAOM  
76 S. Laura Street  
Suite 1290  
Jacksonville, FL 32202  
Fax: 703-548-9079