ONCC Testing Accommodations Request Form

The Oncology Nursing Certification Corporation (ONCC) will provide reasonable accommodations for test candidates with disabilities that are covered under the Americans with Disabilities Act (ADA), as amended. Candidates requesting testing accommodations must submit the Testing Accommodations Request Form by mail or fax within five business days of applying. In addition:

1. You must complete and submit the ONCC Testing Accommodations Form within five days of applying to test.
2. Additional documentation may be requested to support the request for testing accommodations. You are responsible for obtaining any additional documentation requested by ONCC.
3. All documentation submitted in support of a request for testing accommodations, including this form, will be kept confidential.
4. After your test application and accommodations are approved, ONCC will send you an email with a link to an additional form that must be completed and submitted to PSI (the test delivery vendor) to ensure the appropriate accommodations are provided. You should wait until you receive your ATT to complete and submit the form to PSI.
5. PSI will schedule your testing appointment and send you an email confirmation. If your preferred appointment time cannot be accommodated, PSI will contact you to schedule an appointment.
6. Test results reports will contain no indication that a test was taken with a testing accommodation.
7. All ONCC tests are administered by computer-based testing. There is NO paper and pencil test available.
8. Questions should be directed to ONCC (via email or by telephone 877-769-6622).

SECTION ONE: TO BE COMPLETED BY THE CANDIDATE REQUESTING TESTING ACCOMMODATIONS

Last Name _____ First Name _____ Middle Initial _____

Home Address _____

City _____ State _____ Zip Code _____

Home/Cell Phone Number _____ Email Address _____

Test: ☐ OCN® ☐ AOCNP® ☐ CBCN® ☐ CPHON® ☐ BMTCN®

SECTION TWO: TO BE COMPLETED BY A LICENSED PHYSICIAN (MD/DO), PSYCHIATRIST, OR CLINICAL PSYCHOLOGIST

The professional evaluation must have been made by a licensed individual who is qualified to diagnose the specific illness, and been made no earlier than three years prior to application.

Specific Diagnosis(es) _____

Treatment/Medication History _____

Date of Initial Diagnosis and Treatment _____ Date of most Recent Evaluation _____

Current Treatment/Medication Status _____

List the specific diagnosis tests performed and conclusion based on diagnostic tests: _____

Describe accommodations that have been provided in the past: _____

Specific recommended accommodation(s) for the certification test (check all that apply):

- ☐ Special seating or other physical accommodation _____
- ☐ Extended testing time (indicate whether 1.5 hours or 3 hours of additional time is required)
- ☐ Separate testing room
- ☐ Other, please describe: _____

Professional's Name _____ Credentials _____

Address _____

City _____ State _____ Zip code _____

Phone Number _____ Email Address _____

Professional License Number _____ State of Licensure _____

Specialty certification/qualifications _____

Signature _____ Date _____

Return this completed form (and any additional documentation you wish to submit) to oncc@oncc.org or by fax to 412-859-6168 within 5 days of applying.