International WELL Building Institute™

VERIFICATION BY QUALIFIED HEALTHCARE PROVIDER FORM FOR TESTING ACCOMMODATIONS

I, _____, (print candidate name)
hereby authorize and request the healthcare professional ("Provider") identified below to release the information requested by International WELL Building Institute™ (IWBI™) relating to my disability and the accommodation appropriate to my disability to sit for any credentialing program offered by IWBI. I have provided the Healthcare Provider with the current information about the format of the credentialing exam for which I am requesting accommodations (e.g., amount of time allotted; flexible breaks and taking medication, etc.).

Candidate's Signature: _____ Date: _____

To be completed by a Healthcare Provider *(please fill out the form in its entirety)*:

All documents must be submitted, scanned and emailed to accommodations@wellcertified.com. DO NOT MAIL THESE DOCUMENTS.

I would like to request accommodation for _____ (exam candidate) to complete a credentialing exam offered by IWBI™. IWBI's accommodation policy requires candidates requesting accommodation to submit current documentation of the disability from an individual qualified to assess the disability.

Your written evaluation should include your assessment of the required accommodation plan. The documentation should explain the type of disability and how the proposed accommodation affects the disability.

The documentation must include the following information:

1. The assessment of the exam candidate's disability
2. the month, day and year the exam candidate first consulted you;
3. the month, day and year you last saw the exam candidate;
4. the diagnosis of my disability (including the DSM-IV classification for any diagnosis of a learning disability); 5. the name of the diagnostic test(s) used; and
6. the length of the condition.

Continue below:
TO BE COMPLETED BY PROVIDER (please print legibly or type all responses):

RECOMMENDED ACCOMMODATION (how does the accommodation relate to the candidate's disability, given format of the credentialing exam? The request must be specific (e.g., if additional time is needed, indicate how much, etc.):

Provider Name (for verification purposes only): _____
Title and Occupation: _____
Street Address: _____ City: _____ State/Province: _____
Zip/Postal Code: _____ Country: _____ Email

Address: _____ Telephone:

_____

Please provide your license/certification information:

Jurisdiction: _____ License/Certification Number: _____

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 forgoing 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.

Provider Signature: _____ Date: _____

Name (please print): _____