

North Carolina Code Official Qualification Licensure Board

ADA<sup>1</sup> Examinee Accommodation

Request Form:

Home Inspector Licensure Exam

**Information About the Exam:**

The North Carolina Home Inspector Exam evaluates an individual's knowledge of the Standards of Practice and Board Rules pertaining to home inspector duties.

This exam is an on-line computer-based exam where the candidate will be monitored by a human being as well as automated proctoring. The exam can be taken at a location of the examinee's choice. Examinees may use a personal or employer's computer following all the requirements outlined in the NC HILB Exam Administration and Rules.

This is a 200 question, multiple choice test, and no outside reference materials are allowed. A calculator is provided within the exam software, and examinees may adjust the font size on the exam screen. Examinees are not allowed to use paper or writing instruments but may flag exam items they wish to return to in the software.

Applicants may not have food while taking the exam but are encouraged to have beverages.

Please fill-in the "*Information Needed from Examinee*", print the document and take it to your qualified provider or qualified professional.

**Email the completed "ADA Accommodation Request Fillable (HILB).pdf".**

Email: *osfm.quest@ncdoi.gov*

Please type in the Subject Line: **HILB ADA Accommodations** *[Your initials]*

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<sup>1</sup> ADA refers to the Americans with Disability Act, and the Americans with Disability Act As Amended (ADAAA) effective January 1, 2009.

## **Information Needed from Examinee**

**Examinee's Name:**

**Examinee's Contact Information:**

**Phone:**

**Address:**

**Email:**

**Nature of the disability for which you are requesting an accommodation:**

Indicate the nature of your disability, the year it was diagnosed, and the date of your most recent evaluation for this disability:

\_\_\_ Visual

\_\_\_ Physical

\_\_\_ ADHD

\_\_\_ Learning

\_\_\_ Psychological

\_\_\_ Hearing

\_\_\_ Other (specify)

Year of Diagnosis:

Date of most recent evaluation for this disability (mm/dd/yyyy):

**Previous Accommodations:**

Have you received exam accommodations?      Yes      No

If you answered "yes", provide the exam name, exam date, and accommodations received:

Have you previously received other accommodations related to your disability, such as educational or workplace accommodations?      Yes      No

If you answered yes, please describe what accommodations you received, and the dates you received the accommodations:

**Other information:**

You may provide any other information here that you feel will help us in the evaluation of your accommodation request:

**Requested accommodation:**

(Select all that apply)

Extended time.

Other. Please describe requested accommodation. Please note that requesting the accommodation does not guarantee that this specific accommodation will be available.)

Other requested accommodation:

**PROFESSIONAL/PROVIDER ACCOMMODATION FORM**

**Information Needed from**  
**Qualified Professional / Qualified Provider**

**(This section must be completed by a qualified professional or qualified provider who has evaluated or treated the applicant for their disability that is the basis for their ADA accommodation request.)**

**Professional's/Provider's Name:**

\_\_\_\_\_

**Professional's/Provider's Area of Expertise/Credentials (i.e. physician, licensed psychologist, licensed mental health professional, school official, instructor, licensed learning disability specialist, etc.):**

\_\_\_\_\_

**Professional's/Provider's Contact Information:**

**Phone:** \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

**Email:** \_\_\_\_\_

**Nature of Disability:**

Indicate the nature of the applicant's disability:

\_\_\_ Visual

\_\_\_ Physical

\_\_\_ ADHD

\_\_\_ Learning

\_\_\_ Psychological

\_\_\_ Hearing

\_\_\_ Other (specify) \_\_\_\_\_

**Please state when you last evaluated or treated the applicant for this disability:**

\_\_\_\_\_

**Please indicate which, if any, of the examinee's major life activities are substantially limited by their disability:**

\_\_\_ Seeing      \_\_\_ Hearing      \_\_\_ Learning      \_\_\_ Reading

\_\_\_ Concentrating      \_\_\_ Thinking      \_\_\_ Communicating

\_\_\_ Other (please specify) \_\_\_\_\_

**Please indicate which, if any, of the examinee's major bodily functions are substantially limited by their disability:**

\_\_\_ Neurological      \_\_\_ Endocrine      \_\_\_ Digestive/Bladder

\_\_\_ Respiratory      \_\_\_ Circulatory      \_\_\_ Immune

\_\_\_ Other (Please specify) \_\_\_\_\_

**Please provide a brief description of how the examinee's disability impacts their ability to take the exam described above:** \_\_\_\_\_

\_\_\_\_\_

**Please indicate the accommodation that will, in your opinion, best assist the examinee taking the examination:**

\_\_\_ Extended time.

If you selected extended time, please select the amount of extra time that is appropriate to accommodate the examinee:

\_\_\_ 30 minutes      \_\_\_ 1 hour      \_\_\_ 2 hours

\_\_\_ Other length of time (please specify)\_\_\_\_\_

\_\_\_ Other. Please describe recommended accommodation and indicate the reason you are recommending this specific accommodation pertaining to the examinee's disability. (Please note that requesting accommodation does not guarantee that this specific accommodation will be available.)

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Please provide any other information you feel may be helpful in evaluating the examinee's request for ADA exam accommodations:

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\_\_\_\_\_  
Professional/Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Professional/Provider Phone Number

\_\_\_\_\_  
Name of Professional/Provider Institution