

Dental Admission Test (DAT)
Accommodations Request

The Department of Testing Services (DTS) provides reasonable and appropriate accommodations in accordance with the Americans with Disabilities Act for individuals with documented disabilities or a medical condition who demonstrate a need for accommodations and request accommodations prior to testing. Accommodations will not be noted on test results nor shared with any third party (e.g. dental schools, state licensing agencies, etc.).

The Americans with Disabilities Act defines a person with a disability as an individual with a physical or mental impairment that substantially limits one or more major life activities.

English as a second language, test anxiety, or difficulty reading without an identified underlying physical or mental deficit, or failure to achieve a desired outcome are not generally covered by the Americans with Disabilities Act.

Testing accommodations are offered to those with a qualified disability or medical condition to offer equal access to testing.

Candidates must request testing accommodations with each application, but will not be required to submit additional documentation for the same disability or condition with subsequent retest applications.

Request for Testing Accommodations and Appropriate Documentation

The following information will assist the candidate in submitting the appropriate documentation to support the testing accommodations request. The documentation will assist the DTS in determining whether the individual qualifies for accommodations under the Americans with Disabilities Act.

The DTS requires a complete evaluation of the candidate as well as the completed and signed Testing Accommodations Request Form (see below). A health care professional appropriately qualified for evaluating the disability must conduct the evaluation.

If you have a documented disability recognized under the Americans with Disabilities Act and require testing accommodations, you must submit 1) an application to test, 2) the Testing Accommodations Request Form, **and** 3) the supporting documentation prior to testing. Your submission is not complete until you have provided all three components.

Procedures for submitting a testing accommodations request are as follows:

1. While submitting your DAT application, and **prior to scheduling a testing appointment**, select "Yes" from the drop down on the application to indicate you are requesting testing accommodations. After your accommodations request is approved, you will receive an eligibility email with scheduling instructions. You cannot schedule prior to receiving this email. Testing accommodations cannot be added to a previously scheduled testing appointment. If you schedule your testing appointment before the approval of testing accommodations, you will be required to cancel the appointment and pay a reschedule fee. You will receive an eligibility letter, via email, once your accommodations have been approved.

2. Submit the following documents as a **single attachment** to testingaccommodations@ada.org:
 - a. **Testing Accommodations Request Form**, signed and dated, indicating the disability or medical condition, and the need for accommodations. Accommodations should align with the identified functional limitation so that the adjustment to the testing procedure is applicable to the identified impairment. A functional limitation is defined as the behavioral manifestation of the disability that impedes the individual's ability to function.
 - b. **Current evaluation report** (from within the past five years) from the appropriate health care professional. The document must be on official letterhead, and should include the **professional's credentials, signature, address, and telephone number**. The report must indicate the **candidate's name, date of birth, and date of evaluation**. The report should include:
 - information concerning the specific **diagnostic procedures or tests** administered. Diagnostic methods used should be appropriate to the disability and in alignment with current professional protocol.
 - the **results** of the diagnostic procedures and tests and a comprehensive interpretation of the results.
 - the specific **diagnosis of the disability**, with an accompanying description of the candidate's limitations due to the disability.
 - a summary of the complete evaluation with **recommendations for the specific accommodations** and how they will reduce the impact of the identified functional limitation.
 - c. **Documentation of any previous accommodations** provided by educational institutions or other testing agencies. If no prior accommodations were provided, the licensed professional should include a detailed explanation as to why no accommodations were given in the past and why accommodations are needed now.

Unacceptable Forms of Documentation

Please do not submit the following documents. The DTS will not accept them.

- Handwritten letters from licensed professionals
- Handwritten patient records or notes from patient charts
- Diagnoses on prescription pads
- Self-evaluations found on the internet or in any print publication
- Research articles
- Original evaluation documents; please submit copies of the original documents
- Previous correspondence from the DTS. We maintain copies of all correspondence.
- Correspondence from educational institutions or testing agencies not directly addressed to the DTS

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Please return this signed form and supporting documentation (as a single attachment) by email to testingaccommodations@ada.org. Upon receipt, the Department of Testing Services will review your request and notify you by email of the decision.

Personal Information		
First Name	Middle Name	Last Name
Street Address		
City		Daytime Telephone Number
State		DENTPIN®
ZIP Code		

Accommodations History	
Indicate any previous accommodations you have received and the corresponding dates.	
Standardized Examination	Educational Institution
Name of Test:	Name of Educational Institution:
Date(s):	Date(s):
Specific Accommodations Received:	Specific Accommodations Received:
Other:	Other:

Nature of Disability	
Circle or highlight the disability or condition and indicate the year of diagnosis.	
Disability	Year of Diagnosis
Language Impairments	
Expressive Language Disorder	
Receptive Expressive Language Disorder	
Receptive Language Disorder	
Learning Impairments	
Mathematics Disability	
Reading Disability	
Writing Disability	
Medical Impairments	
Diabetes	
Other	
Mental Health Impairments	
Attention Deficit Disorder	
Attention Deficit Hyperactivity Disorder	
General Anxiety Disorder	
Sensory Impairments	
Hearing Disability	
Visual Disability	
Other	

Requested Accommodations

Indicate the specific accommodation(s) you are requesting; accommodations must be applicable to the disability. (Requests will not be processed if no accommodations are requested below.)

Authorization

I, the undersigned, certify that the information I have provided is correct. I give permission to the Department of Testing Services to contact the licensed professional who diagnosed my disability and the educational institution that granted me previous testing accommodation for additional information or clarification as needed. I authorize such professionals and educational institutions to provide the DTS with such clarification and further information as needed.

Candidate's Signature: _____ Date: _____

