

CVPM ADA Compliance Procedures

VHMA and CVPM Board comply with the Americans with Disabilities Act and strive to ensure that no individual with a disability, defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment, is deprived of the opportunity to take the examination solely by reason of that disability. The CVPM Board will provide reasonable accommodations for candidates with disabilities.

If you require special accommodations in order to sit for the examination, you should contact the VHMA administrative office. You and your qualified health care provider will need to complete a form to document the disability and the need for accommodation. You must provide medical documentation of the disability that is less than five years old. This means that you must have a current evaluation from the appropriate provider. The CVPM Board must receive this documentation along with your application submission. You must submit two forms with your application: the Candidate Form and the Provider Form.

These forms require you to provide the:

- Diagnosis and nature of the disability,
- Name of tests used to evaluate the condition and a summary of the positive findings that support the diagnosis of the disability
- Length of the condition
- Date you were last seen
- What accommodation is suggested

The forms should be sent to the VHMA administrative office. Each request will be evaluated individually.

Please contact the VHMA staff if you have any questions regarding special accommodations. The CVPM Board wants to be sure that that candidates have the accommodations they need.

Special Accommodations Forms Attached:

CVPM Request for Accommodations - Candidate Form
CVPM Request for Accommodations - Provider Form
Documentation of Disability-Related Needs Template

CVPM Request for Accommodations - **CANDIDATE FORM**



Please submit this form and related materials to:

Certified Veterinary Practice Manager Board
Veterinary Hospital Managers Association
PO Box 2280, Alachua, FL 32616
518-433-8911/888-795-4520 fax

To request an examination accommodation for a disability, please submit this form with your application by the application deadline. The CVPM Board must receive your completed Candidate Form and Provider Form (and related required evaluation of your disability and the appropriate accommodation) completed from a physician or other health care provider or relevant authority. The provider's documentation should identify (i) the diagnosis and nature of your disability, (ii) the last time the provider saw you and the diagnosis of the disability, (iii) the name of test used, (iv) the length of the condition, and (v) what accommodation is suggested to accommodate the disability.

Name _____

Address _____

Date of Examination _____ Email address _____

Telephone: Day (_____) _____ Evening (_____) _____

Description of Disability: _____

Requested Accommodation: _____

Previous Accommodation (if any): _____

I understand that CVPM Board will use the information obtained by this authorization to determine eligibility for a reasonable accommodation in regard to this examination by reason of my disability.

Under penalty of perjury, I declare that the foregoing statements and those in any required accompanying documents or statements are true. I understand that false information may be cause for denial or revocation of certification. I hereby certify that I personally completed this portion and that I may be asked to verify the above information at any time.

Signature _____ Date _____

Please note that the PROVIDER FORM, in addition to the letterhead evaluation from the provider, must be completed by a physician or licensed health care provider appropriate to the disability.

CVPM Request for Accommodations - **PROVIDER FORM**



Please submit this form and related materials to:

Certified Veterinary Practice Manager Board
Veterinary Hospital Managers Association
PO Box 2280, Alachua, FL 32616
518-433-8911/888-795-4520 fax

I, _____ (printed name of candidate), hereby authorize and request the provider identified below to release the information requested by CVPM Board relating to my disability and the accommodation appropriate to my disability to sit for the CVPM examination.

Signed: _____ Date: _____

The candidate/patient identified above is requesting accommodation to sit for the Certified Veterinary Practice Manager (CVPM) examination. CVPM's accommodation policy requires candidates requesting accommodation to submit current documentation of the disability from an individual qualified to assess the disability. The candidate is requesting that you provide such documentation; you should submit your evaluation on your professional letterhead.

Your evaluation should include your assessment of the candidate's disability, as well as an accommodation plan. The documentation should explain the type and degree of the candidate's disability and how the proposed accommodation affects the disability.

The documentation should include the following information: (i) the month, day and year the candidate/patient first consulted you; (ii) the month, day and year the candidate/patient was last seen by you; (iii) the diagnosis of the candidate/patient's disability; (iv) the name of the tests used; and (v) the length of the condition.

You are also required to include recommended accommodations for testing in the documentation. Finally, please sign the statement below and include it in the transmittal of your evaluation.

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 the foregoing 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.

Signature _____

Name (please print) _____ Date _____

Address _____

Telephone: (_____) _____ State License #: _____

If you are not licensed, please note credentials that allow you to diagnose the disability:

Documentation of Disability-Related Needs



Please have this section completed by the appropriate professional (physician, psychologist, or psychiatrist) to ensure that CVPM Board is able to provide the necessary examination accommodations. If you have questions, please call VHMA Office at 518-433-8911.

Submit this form along with your Special Accommodation CANDIDATE and PROVIDER forms with your CVPM Application and examination fee.

Send to: mail: CVPM Board, VHMA Office, PO 2280, Alachua, FL 32616, U.S.

fax: +1 888-795-4520 | **email:** CVPM@vhma.org | **phone:** +1 518-433-8911 or 877-599-2707

PROFESSIONAL DOCUMENTATION

I have known _____ since ____/____/____
Examination Candidate Month Day Year

in my capacity as a _____
Professional Title

I last saw _____ on ____/____/____
Examination Candidate Month Day Year

It is my opinion that, because of this candidate's disability/diagnosis described below.

Disability/Diagnosis: _____

Method of Determination/Tests Used: _____

Length of the Condition: _____

They should be accommodated by providing the following requested special arrangements.

Arrangements: _____

PROFESSIONAL'S CONTACT INFORMATION

Printed Name

Title

Mailing Address

Daytime phone number

License Number (if applicable)

Signature

Date