

Professional Licensing Agency
402 West Washington Street
Room W072
Indianapolis, Indiana 46204



Mike Braun
Governor of Indiana
Lindsay M. Hyer
IPLA Executive Director

NCLEX TESTING ACCOMMODATIONS – FORM B

Instructions: This form should be completed by the disability coordinator, dean, director, or an authorized representative of the nursing education program where the applicant attended. The representative may complete this form or provide the required information in a signed letter. If no testing accommodations were provided to the applicant during nursing school, the applicant must so indicate by signing the bottom of the form.

Applicant Name: _____ Date of Birth: _____
(Last, First Middle) (MM/DD/YYYY)

1. Identify detailed diagnosis and accommodations that were provided while applicant attended the nursing program.
2. Describe the types of examinations administered and the testing modifications that were provided for the above applicant while attending your nursing program.

NURSING PROGRAM VERIFICATION

Name of Dean/Director/Representative: _____

Name of School: _____

Address: _____ Phone: _____

Signature: _____ Date: _____

If no testing accommodations were provided by the nursing education program, the applicant shall sign below:

Applicant's Signature: _____ Date: _____