BUSINESS STANDARD DIVISION
MONTANA BOARD OF PLUMBERS
301 South Park, PO Box 200513
Helena, MT 59620-0513
Phone: (406) 444-6880
E-Mail: dlibsdhelp@mt.gov
WEBSITE: www.plumber.mt.gov

The Business Standard Division (BSD) Montana Board of Plumbers (MBOP) grants qualified individuals with disabilities who participate in the examination process protection from unlawful discrimination. Specifically, MBOP will make any reasonable modification to its policies, practices and procedures to accommodate an individual with a disability. While MBOP is not required to provide accommodations that fundamentally alter the nature of the examination, MBOP will strive to provide individuals with disabilities the opportunity to meaningfully participate in the examination process. If you have a disability which may require accommodation of the examination process or access to the examination center, you must submit with your application the following Information:

1. Request for Accommodation Form completed and signed.

2. The appropriate verification for the needs for an accommodation from a health care provider.

IF YOU DO NOT SUBMIT THIS INFORMATION WITH YOUR APPLICATION OR IF YOU ONLY SUBMIT PARTIAL OR INCOMPLETE INFORMATION YOUR EXAMINATION COULD BE DELAYED.

MBOP will not pay for any costs incurred in obtaining the appropriate verification for an accommodation. Please note, any examination accommodation, including aids brought to a testing center, must be pre-approved by the MBOP.

REQUST FOR MODIFICATION IN THE ADMINISTRATON OF THE PLUMBING EXAMINATION OR EXAMINATIONS.

NAME: ____
(First) (Middle) (Last)

ADDRESS: ____
(Street) (City) (State) (Zip Code)

DAYTIME PHONE: ______________ EMAIL ADDRESS (OPTIONAL): ______________

Note: It is important that you provide current contact information and advise the MBOP of any changes to this address while this request is being processed.

1. Please describe the nature of the disability (e.g. physical, mental, learning) and how this disability limits a major life activity.

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2. How does this disability affect your ability to take the examination as it is typically provided by MBOP?

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3. Please describe the accommodation or accommodations that you are seeking, please be specific (e.g. do not say additional time for testing, specify how much additional time).

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Please have your health care provider either fill-out and sign MBOP's "Medical Verification Form" or attach documentation from an appropriate health care provider that meets the following criteria:

a. Describe the health care provider's credentials and experience to ascertain your need for an accommodation.

b. Describe the specific diagnosis of disability/or the manner in which the impairments limit your ability to perform a major life activity;

c. Describe how the diagnosis of disability impacts your ability to function in regard to the examination process; and

d. Set forth the specific accommodations.

SIGNATURE: ______________________________ DATE: ____________________

I understand that this request and all documentation concerning this request is considered confidential; however, by signing this request, I agree that MBOP has permission to share pertinent information regarding my disability when necessary to the provision of any accommodation provided.

MEDICAL VERIFICATION OF NEED FOR ACCOMODATION

You have been asked to provide medical verification regarding the need for

an accommodation for____.
(Candidate's full-name)

1. Please describe your credentials and experience which qualify you to make the determination of the disability and the recommended accommodation.

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2. When was the last time you examined the candidate?

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3. Please describe the type and nature of the candidate's disability and how it limits one or more of the candidate's major life activities.

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4. Please describe how the disability affects the candidate's ability to perform under normal conditions.

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5. What is the recommended accommodation and please be specific (e.g. candidate requires 50% additional time, special seating, ESL interpreter)?

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6. Additional Comments:

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____
Health Care Provider (printed) (Title)

____ ____________________
Signature of Health Care Provider Date