American Association of Veterinary State Boards

PAVE Qualifying Science Examination Application for Accommodations

Overview

The American Association of Veterinary State Boards (AAVSB) is committed to the principle of testing individuals in a manner that will yield valid and reliable examination results. In some instances, the examination administration procedures may need to be modified to provide reasonable accommodations for PAVE Qualifying Science Examination candidates with disabilities.

The AAVSB Board of Directors reviews and approves all accommodation requests. The Accommodations Application provides the necessary information for the AAVSB Board of Directors to determine:

1. whether a PAVE candidate is a qualified disabled individual under U.S. or Canadian federal law, and
2. whether the accommodation being requested is reasonable. Consideration of all requests will be made under applicable laws, including the Americans with Disabilities Act Amendment Act of 2008, the Canadian Employment Equity Act, the Canadian Human Rights Code and the Ontario Human Rights Code.

A submitted Accommodations Application will remain on file with AAVSB. A previously approved accommodations request will be reviewed by the AAVSB Board of Directors for any subsequent examinations provided the candidate makes a request through the online PAVE examination application.

Applications will not be returned to the applicant.

Instructions

PAVE Candidates must follow the instructions below to complete the Accommodations Application. The application and required supporting documents are to be received and at the AAVSB office by the PAVE online application and documents deadline of the selected examination window. ***Please refer to AAVSB website for posted deadlines.***

1. **Complete the online PAVE Qualifying Science examination application** at www.aavsb.org no later than the posted deadline. In the application, indicate "yes" that special accommodations are being requested.
2. Complete **Section I** of the Accommodations Application. A Social Security number is not required, but the last four digits will assist in identifying and matching the Accommodation form to the submitted PAVE application. (Section I is to be mailed directly to the AAVSB. The AAVSB recommends to scan and email Section I to pave@aavsb.org prior to mailing.)
3. Request licensed health care practitioner or other appropriate licensed professional to complete Section II of the application. (Section II can be mailed directly to the AAVSB and initially scanned/emailed to pave@aavsb.org.)
4. **Submit copies of supporting documentation for the accommodation request.** (Documentation can be scanned and emailed by candidate or college to pave@aavsb.org as applicable):
   Diagnostic reports
   IEPs
   504 Plans
   College accommodation forms

Keep a copy of the completed Accommodations application and supporting documentation for your records.

5. **Mail completed Sections I and II with all supporting documentation, to be received no later than PAVE application and documents deadline to the following address:**

PAVE
AAVSB
380 West 22nd Street
Suite 101
Kansas City, MO 64108

For questions, contact the PAVE program at pave@aavsb.org or call 1-877-698-8482 during business hours.

Candidates needing accommodations who cannot use the online application should email pave@aavsb.org or call 1-877-698-8482 to make other arrangements for submitting an application.

Please visit the AAVSB website at www.aavsb.org for examination application and deadline information.

Revised 1-2019

American Association of Veterinary State Boards

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Section I – To Be Completed by PAVE Candidate

Name_____
Last First M.I.

SSN# xxx -_xx -_____
Optional (last 4 digits)

Address_____

Birth Date _____-_____-_____

City, State Zip code_____

Exam (month/day/year) for which you are applying:

_____

Daytime Phone Number_____
Evening Phone Number_____

Email Address _____

Major life activity impaired by disabling condition: _____

Accommodations requested by PAVE Candidate: _____

_____

Name of physician(s) or other health practitioner(s):

(a) Name_____

Office Address_____
Street City State Zipcode

Length of time as patient_____

(b) Name_____

Office Address_____
Street City State Zipcode

Length of time as patient_____

Release

I authorize each health care practitioner above to release to the American Association of Veterinary State Boards (AAVSB), or their designated representatives, information which will verify the current functional limitations imposed by my disability which affect my ability to perform under standard testing conditions; and describe the nature of the examination accommodation(s) being proposed and the rationale for those accommodation(s). I further understand that I may be asked to provide additional information about my functional limitation(s) and the requested accommodations and agree to cooperate with reasonable requests for such additional information.

I understand and agree that the information obtained by this authorization will be used solely for the purpose of determining my eligibility for reasonable accommodations in regard to taking the PAVE's Qualifying Science Examination (QSE) and the nature and extent of the accommodations which are reasonably necessary by reason of my disability. The information obtained by this authorization will not be released or disclosed to any person or organization except the referenced parties, and any other governmental agency that may be involved in acting upon my request for reasonable accommodations in connection with taking the QSE as part of the PAVE program.

I agree that this authorization shall be valid until canceled or revoked in writing by me.

Under penalties 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 loss of a license. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time.

Signature_____ Date_____

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Section II – To be Completed by Licensed Physician/Licensed Health Care Practitioner

Each physician or health care practitioner providing services to the PAVE Candidate should complete one copy of this form.

Practitioner Name_____
Last First M.I.

Office Address_____
Street City State Zipcode

Telephone Number_____

Patient's Name_____

Patient's Address_____
Street City State Zipcode

Patient's SSN#__XXX__-_XX__-_____
Optional (last 4 digits)

Date patient first seen (month/year)_____ Date patient last seen (month/year)_____

1. Diagnosis and description of disabling condition* (Please provide any other necessary information including codes and tests administered to determine condition)_____

_____

2. Date of onset_____

3. Major life activity(ies) limited by disabling condition _____

_____

4. Previous accommodations granted and when _____

_____

5. Accommodation(s) requested in this testing situation_____

_____

I hereby certify that the above information is true and is released pursuant to authorization by my patient.

Signature of Licensed Heath Care Practitioner _____

Professional Status _____
Physician, Psychologist, etc.

License Number _____

Date _____
Month Day Year

***Please include additional supporting documents i.e., Diagnostic reports**