



NATIONAL BOARD OF  
PHYSICIAN NUTRITION  
SPECIALISTS

**Certification Exam Special Accommodations Form**

To be completed by certification applicant.

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Please describe the disability/condition that impairs your ability to complete the NBPNS Examination.**

**Please list the specific testing accommodation requested.**

**Note:** *Following review, you may be asked to provide written documentation from a licensed or certified healthcare provider supporting the need for the accommodation requested.*