U.S. PATENT AND TRADEMARK OFFICE OMB No. 0651-0012 | Approved through 2/28/2021 | **FORM PTO-158RA**

REQUEST FOR REASONABLE ACCOMMODATION

APPLICANT'S STATEMENT

1. NAME OF APPLICANT ◯Mr. ◯Ms.	Last Name	First Name	Middle Name

1a. APPLICANT'S ADDRESS (street, bldg., suite, etc.)

1b. E-MAIL ADDRESS	**1c.** PHONE NUMBER
2. LOCATION OF EXAM	**3.** DATE OF EXAM

4. Describe applicant's medical condition(s) (*i.e.*, illness, disease, or injury) and how it (they) interfere(s) with applicant's ability to complete the registration examination in the standard time allotted and/or in the standard conditions

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5. Please provide the date of the most recent evaluation of applicant's disability

_____

6. Did applicant apply for and receive nonstandard testing accommodation for classroom examinations and/or admissions tests? ◯ YES ◯ NO

IF YES, (1) check all that apply (2) describe the specific accommodations, (3) specify amount of additional time received, and (4) if applicable, please note if accommodations were denied.

	ACCOMMODATIONS	**ADDITIONAL TIME GRANTED**	**DENIED**
☐ Grade School			
☐ High School			
☐ College			
☐ Law School			
☐ SAT			
☐ LSAT			
☐ MPRE			
☐ GMAT			
☐ Bar Exam			
☐ Other	please specify:		
☐ None			

6a. Please provide supporting documentation for the accommodations received above.

6b. If applicant was denied for any of the above, please explain and attach relevant documentation.

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7. Has applicant previously applied to take a registration examination(s)? ◯YES ◯NO

7a. Did applicant request any accommodations? ◯ YES ◯NO

IF YES, complete the following and provide supporting documentation:

Date of Exam	Accommodation Received

8. Describe specifically what accommodation(s) applicant thinks could be made so that the test results accurately reflect applicant's knowledge of patent laws, rules and procedures rather than reflecting any impairment to applicant's abilities from a disability. Note that any accommodation applicant requests must be supported by the Licensed Health Care Professional's statement(s) applicant submits (e.g., if applicant requests twice the amount of time to take the exam, then one of the Licensed Health Care Professional statements applicant submits must indicate that applicant needs twice the amount of time to take the exam and explain why applicant needs twice the amount of time).

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PRIVACY ACT STATEMENT AND CERTIFICATION AND CONSENT BY THE APPLICANT

The USPTO will process requests for reasonable accommodation and, where appropriate, provide reasonable accommodations in a prompt, fair and efficient manner.

The Privacy Act of 1974 (P.L. 93-579), 5 U.S.C. § 552a(e)(3), requires that applicant be given certain information in connection with the request for personal information solicited on the Request for Reasonable Accommodation forms. Accordingly, please be advised that (i) the authority for the collection of this information is 35 U.S.C. § 2(b)(2)(D) and Section 504 of the Rehabilitation Act, (ii) furnishing of the information solicited is voluntary, and (iii) the principal purpose for which the information will be used is to process requests for reasonable accommodation for the registration examination to practice before the United States Patent and Trademark Office (USPTO) in patent cases. If applicant does not furnish the requested information, the USPTO may not have the information necessary to grant applicant's request for reasonable accommodation. Routine uses of the information applicant provides on these forms may include disclosure to USPTO staff or other authorized personnel who require access to this information in the performance of their duties in processing these requests and administering an accommodation to applicant.

Under the Rehabilitation Act, medical information obtained in connection with the reasonable accommodation process must be kept confidential. This means that all medical information, including information about functional limitations and reasonable accommodation needs that USPTO obtains in connection with a request for reasonable accommodation, must be kept in files separate from the individual's application file. The information provided by applicant will be used primarily to facilitate the processing of applicant's request for accommodation. Only parties who need to know this information as necessary and appropriate to make a determination about applicant's request for reasonable accommodation will have access to this information.

All records obtained or created during the processing of a request for reasonable accommodation, including medical records, will be kept in the applicant's medical file and will be maintained in accordance with the Privacy Act and the requirements of 29 CFR Part 1611.

I hereby certify that all statements made above are true to the best of my knowledge and belief. I hereby give permission for the release of information about my medical condition(s) to authorized agency officials.

_____ _____

Applicant's signature (do not print) Date

APPLICANT'S CONSENT TO RELEASE MEDICAL INFORMATION

I authorize the release to the United States Patent and Trademark Office of any and all information or records connected with my physical/mental impairment(s) (illness, disease, or injury) which are the basis of my Request for Reasonable Accommodation.

_____ _____

Applicant's signature (do not print) Date

_____

Applicant's name (type or print)

REQUEST FOR REASONABLE ACCOMMODATION

LICENSED HEALTH CARE PROFESSIONAL'S STATEMENT

Applicant seeks to take the examination for registration to practice in patent cases before the United States Patent and Trademark Office (USPTO). The registration examination consists of 100 multiple choice questions. The exam is split into a morning session of 3 hours and an afternoon session of 3 hours. Fifty questions are asked during each of those sessions. Applicant is asking the USPTO to alter how the exam is administered because he/she has a disability(ies) that prevents him/her from completing the exam in the allotted time and/or under the standard conditions. Applicant is required to submit medical documentation to demonstrate that he/she has a physical or mental impairment that substantially limits one or more of his/her major life activities and to support his/her request for a reasonable accommodation. The Office of Enrollment and Discipline (OED) at the USPTO has developed this Licensed Health Care Professional's Statement to assist medical professionals in providing the type of information that OED needs to determine whether a reasonable accommodation is warranted.

Applicant is responsible for any costs incurred in connection with providing this documentation.

A new medical examination is not necessary if the Licensed Health Care Professional can provide current information from his/her records.

Enclose this completed Licensed Health Care Professional's Statement and any attachments in a sealed envelope marked "CONFIDENTIAL MEDICAL RECORDS." Send it to the address shown below. Alternatively, it may be given directly to the applicant for delivery to OED at the USPTO.

Address to which Licensed Health Care Professional can mail statement:

U. S. Patent and Trademark Office
Mail Stop OED
Director of the US Patent and Trademark Office
PO Box 1450
Alexandria, VA 22313-1450

FAX: (571) 273-4097
E-mail: OED Reasonable Accommodations@USPTO.gov

Please complete this statement within 2 weeks. Please note that illegible or incomplete statements will not be accepted. Furthermore, additional sheets and reports may be attached, if necessary, to fully respond to any questions. Incomplete answers may result in the rejection of this statement and ultimately the applicant's request for a reasonable accommodation.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1a. PATIENT'S NAME Last Name First Name Middle Name

◯ Mr. ◯ Ms.

1b. PATIENT'S ADDRESS (street, bldg., suite, etc.)

2. LICENSED HEALTH CARE PROFESSIONAL COMPLETING THIS FORM:

2a. NAME	**2b.** PROFESSION:
2c. OFFICE ADDRESS:	
2d. TELEPHONE NUMBER:	**2e.** E-MAIL ADDRESS:

3. Please provide a full explanation of your qualifications to submit this statement (include relevant education, certifications, licenses and professional history):

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4. _____ was my patient from _____ to _____ and (◯DID ◯DID NOT) become my patient, in part, for the purpose of procuring a report to be submitted to obtain nonstandard testing accommodations for taking of an examination.

5. My specific diagnosis (ICD 9 code and/or DSM IV code) for the patient's condition(s) or illness creating a disability is as follows:

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6. A full explanation of the basis for my diagnosis is as follows:

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7. The specific and detailed nature and extent of the disability:

7a. Is the applicant substantially limited in a major life activity? ◯ YES ◯ NO

7b. IF YES, state what activities are affected:

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8. The applicant's illness or condition is: ◯ permanent ◯ temporary (check one)

8a. If temporary, the disability will terminate on _____

9. The date of the onset of the patient's illness or condition was _____

10. I last examined the patient on _____

11. Test(s) administered and dates thereof:

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12. Copies of the test results and reports concerning the tests are attached hereto: ◯ YES ◯ NO

13. If such copies are not attached, the reason for their absence is:

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14. In the case of ADHD:

14a. Did the applicant have a previously documented history of ADHD at the time of your evaluation? ◯ YES ◯ NO.

IF YES, briefly describe below. If no, what objective evidence has been presented for your review that supports a likely history of undiagnosed ADHD (e.g., school records and previous psychological tests)?

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14b. Does the applicant exhibit clinically significant impairment across multiple life domains (e.g., academic, work, social, etc.)?

◯ YES ◯ NO.

IF YES, briefly describe:

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15. My treatment of the applicant consists of:

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16. As a result of my examination, tests and treatment of the patient, I have made the following findings and conclusions:

a. Presenting complaints:

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b. Objective findings:

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17. In your medical opinion, what accommodations would you recommend that your patient receive to be able to have the results of the registration examination accurately reflect his/her knowledge of patent laws, rules and procedures, rather than any impairment that results from his/her disability? Examples of accommodations USPTO has given in the past are an exam with larger font, additional time, a separate testing room from the main testing room, and additional lighting.

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18. Provide a full description of the basis for the recommended nonstandard testing accommodations:

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I hereby declare that all statements made herein of my own knowledge are true and that all statements made on information and belief are believed to be true; and further that these statements were made with the knowledge that willful false statements and the like so made are punishable by fine or imprisonment, or both, under 18 U.S.C. 1001.

Executed on _____ / _____ / _____ at _____ By _____

Date City and State Signature

_____

Type or Print Name

_____

State License Number