

REQUEST FOR SPECIAL NEEDS ACCOMMODATIONS

If you are requesting special testing accommodations and have a disability covered by the Americans with Disabilities Act, please complete this form. The information you provide and any documentation regarding your disability and special testing accommodations will be held in strict confidence. **This form must be uploaded or sent with your application at least 8 weeks before the testing period begins.**

Candidate Information

Name of Examination

Testing Period

Name (Last, First, Middle Initial)

Address

City State Zip Code

Daytime Telephone Number

E-mail Address

Special Accommodations

I request special accommodations as follows: (Check all that apply)

_____ Special seating or other physical accommodation

_____ Reader

_____ Scribe

_____ Extended testing time _____
Specify Total hours requested

_____ Distraction-free room / Tested separately

_____ Other special accommodations (Please specify.)

Signed: _____ Date: _____

Candidate Signature

DOCUMENTATION OF SPECIAL NEEDS

Please have this section completed by an appropriate health care professional (e.g., physician, psychologist, psychiatrist)

Professional Documentation

I have evaluated _____ on ____/____/____ in my capacity as a
Examination Candidate Month Day Year

Professional Title

The candidate discussed with me the nature of the examination to be administered. It is my opinion that, because of this candidate's disability described below, he/she should receive the special testing accommodations listed above.

Description of disability: _____

Signed: _____ Title: _____

Professional's Name: _____

Address: _____

Telephone Number: _____ E-mail Address: _____

Date: _____ License # (if applicable): _____