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.

Candidate Information

_____
Name of Examination

_____
Test Date

_____
Name (Last, First, Middle Initial)

_____
Address

_____
City *State* *Zip Code*

_____
Daytime Telephone Number

_____
Fax 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 administrated. 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):_____

Return this completed & signed form with your application and fees, at least 8 weeks prior to the test date, to:

PROFESSIONAL TESTING CORPORATION
1350 BROADWAY • 17TH FLOOR, NEW YORK 10018

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