



# REQUEST FOR SPECIAL NEEDS ACCOMMODATIONS

## Part II - Qualified Healthcare Professional Attestation

This section must be completed by a qualified healthcare professional who is licensed and has expertise in the disability for which these accommodations are sought. The qualified professional must have evaluated the candidate and is familiar with the candidate's condition.

### 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 requested.

**Description of Disability:** \_\_\_\_\_

**Diagnosis code(s):** \_\_\_\_\_

Are you licensed to diagnose the disability described in this Form? YES \_\_\_\_\_ NO \_\_\_\_\_

Date of disability onset: \_\_\_\_\_

Major life activity impaired by disability condition: \_\_\_\_\_

Signed: \_\_\_\_\_ Title: \_\_\_\_\_

Qualified Professional's Name (Print Name): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date: \_\_\_\_\_ License #: \_\_\_\_\_

Type of license: \_\_\_\_\_

State in which licensed: \_\_\_\_\_