This Request for Test Accommodations must be completed if you are an individual with a disability covered under the Americans with Disabilities Act (ADA) and would like to request test accommodations. Under the ADA, an individual with a disability is a person who has a physical or mental impairment that substantially limits a major life activity (such as seeing, hearing, learning, reading, concentrating, walking) or a major bodily function (such as the neurological, endocrine or digestive system). The information you provide and any documentation regarding your disability and test accommodations will be held in strict confidence. This Form MUST be submitted with your application and received at least 8 weeks prior to the start of your testing period. Forms received after your application has been submitted and less than 8 weeks prior to the start of your testing period may result in a delay in processing. This Form is valid for two years from the date you signed it below. After two years, you will need to complete and submit a new Form.

Candidate Information - Part I

Name of Examination

Testing Period

Name (Last, First, Middle Initial)

Address

City State Zip Code

Daytime Telephone Number

E-mail Address

Test Accommodations

I request Test Accommodations as follows: (Check all that apply)

_____ Reader

_____ Scribe

_____ Extended testing time _______________________

_____ Tested separately

_____ Other test accommodations (Please be specific)

Have you received the same or similar test accommodations while in an academic setting?

NO _____ YES _____

If yes, provide the year(s) that you received these accommodations. If no, please explain below.

Signed: __________________________ Date: ___________

Candidate Signature

Continue to next page for Part II
REQUEST FOR TEST ACCOMMODATIONS FORM

Part II - Qualified Healthcare Professional Section

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 Candidate Name

__________________________________________                        Professional Title

Month    Day        Year

____________________________________________________________________.

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 test accommodations requested. Please type or print clearly.

Description of Disability: ____________________________________________

____________________________________________________________________

____________________________________________________________________

Diagnosis code(s): ____________________________________________________

Are you licensed to diagnose the disability described in this Form?   No _____      Yes _____

Date of disability onset: _____________________________

Major life activity impaired by disability condition: _______________________

For a diagnosis of generalized anxiety disorder, please provide the additional information

1. Has this person had anxiety for more than 6 months?   No___   Yes____

2. Is the anxiety excessive and interferes significantly with psychosocial functioning?   No___   Yes___

3. Does this person have anxiety about a variety of life events or activities?  No_____   Yes_____ indicate the number of activities impacted:   ______________

4. Is the anxiety associated with 3 or more of the following: restless, easily fatigued, sleep disturbance, difficulty concentrating, irritability, muscle tension?   No__   Yes___

Signed: ________________________________________________   Title: ______________________________________________

Qualified Professional’s Name (Print Name): ______________________________________________________________________

Address: __________________________________________________________________________________________________

Telephone Number: __________________________  E-mail:________________________________________________________

Date: __________________________  License #:_______________________________________________________________

Type of license: ______________________________________________

State in which licensed: __________