REQUEST FOR TEST ACCOMMODATIONS FORM

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 _____
Number of extra hours requested

_____ 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

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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 *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 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: _____