REQUEST FOR TEST ACCOMMODATIONS FORM

This Request for Test Accommodations Form 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 or may not be able to be processed for the testing window you applied for.*** The content and validity of the examination shall not be compromised by these accommodations.

Please Type or Print Clearly

To be completed by the candidate

Name of Examination (IgCN® or IgCP®)

Testing Window (Month and Year of Test)

Name (Last, First, MI)

Address

City State Zip

Phone Email

Have you received the same or similar accommodations while in an academic setting?
No_____ Yes_____
If yes, provide the years you received accommodations. If no, provide the reason here:

_____

_____

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 administered. 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: _____

Test Accommodations Requested

Extended Testing Time:

_____ Time and a half _____ Double Time

_____ Other (please explain) _____

Signed: _____

Licensed Professional's Name (Print):_____

Professional Credential/Title: _____

Address:_____

Telephone Number: _____Email:_____

Date: _____ License Number:_____

Type of License: _____ State(s) of Licensure:_____