REQUEST FOR TEST ACCOMMODATIONS

This Form must be fully 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 completed Request for Test Accommodations 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.***

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 _____
Specify total hours requested

_____ Tested separately

_____ Other test accommodations (Please be specific)

_____

_____

_____

Have you received the same or similar test accommodations in the past? (If no, please explain below)

YES _____ NO ____

_____

_____

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
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 test 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: _____