

# Special Testing Accommodations Request Form

Please type or print your responses below.

1. For which examination are accommodations being requested?

2. Name

Last

First

Middle Initial

3. Address

Street

City

State/Province

Zip Code

Email

Daytime Telephone Number

4. Please identify and describe your disability:

5. How long ago was your disability first professionally diagnosed? (mark one)

Less than 1 year

1 - 2 years

2 - 4 years

5 or more years

6. Describe the accommodations being requested:

7. Please attach documentation from a qualified diagnosing professional with (1) the specific diagnosis of the disability and (2) a recommendation for a testing accommodation.

8. Certification/Authorization:

I certify that the above information is true and accurate. If test accommodations provided to me include a deviation from the standard testing time schedule, I agree that, from the time I begin my examination until I have completed it, I will not communicate in any way with any other individuals taking the examination and I will not communicate in any way with such individuals about the content of the examination.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If clarification of further information regarding the documentation provided is needed, I authorize the Association to contact the professional who diagnosed the disability and/or those entities which have provided me test accommodations.

Signature \_\_\_\_\_ Date \_\_\_\_\_