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 _____