Request for Testing Accommodations Form

First Name | Last Name | Credentials

Name exactly as you would like it to appear on your certificate

Employer | Job Title

Address

City | State/Province | Zip/Postal Code

Country | Mobile Phone | Work Phone

Email

Special Testing Accommodations

I request special accommodations as follows (check all that apply):

- ☐ Special seating or other physical accommodation
- ☐ Extended exam time
- ☐ Separate exam room
- ☐ Other (please describe): _____

Candidate's Name | Signature | Date

Professional Documentation

Professional evaluation must have been made no earlier than 3 years prior to application

I have evaluated _____ on ____ / ____ / _____ in my
candidate name date

capacity as a_____. I have been informed of the nature of the
professional title

examination to be administered. It is my opinion that because of this candidate's disability, as described below, he/she should receive the special testing accommodations requested above.

Description of disability (please attach any supporting documentation):

_____

_____

_____

If extra exam time is recommended, please specify the amount of time requested (e.g. 1 extra hour):_____

Professional's First Name	Professional's Last Name	Credentials
Professional License Number	State/Province of Issue	
Employer		Job Title
Address		
City	State/Province	Zip/Postal Code
Country	Mobile Phone	Work Phone
Email		
Printed Name	Signature	Date