

REQUEST FOR SPECIAL NEEDS ACCOMMODATIONS

If you are requesting special testing accommodations and have a disability covered by the Americans with Disabilities Act, please complete this form. The information you provide and any documentation regarding your disability and special testing accommodations will be held in strict confidence.

Candidate Information

Name of Examination

Test Date

Name (Last, First, Middle Initial)

Address

City State Zip Code

Daytime Telephone Number

Fax Number

E-mail Address

Special Accommodations

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

____ Special seating or other physical accommodation

____ Reader

____ Scribe

____ Extended testing time _____
Specify Total hours requested

____ Distraction-free room / Tested separately

____ Other special accommodations (Please specify.)

Signed: _____ Date: _____
Candidate Signature

DOCUMENTATION OF SPECIAL NEEDS

Please have this section completed by an appropriate health care professional (e.g., physician, psychologist, psychiatrist)

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

Description of disability: _____

Signed: _____ Title: _____

Professional's Name: _____

Address: _____

Telephone Number: _____ E-mail Address: _____

Date: _____ License # (if applicable): _____

Return this completed & signed form with your application and fees, at least 8 weeks prior to the test date, to:



PROFESSIONAL TESTING CORPORATION
1350 BROADWAY • 17TH FLOOR, NEW YORK 10018

