

# 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 • 17<sup>TH</sup> FLOOR, NEW YORK 10018

PTC08143