



Testing Accommodations Documentation of Disability-Related Needs Form

If you have a disability that requires an accommodation to take the registration examination, please have this section completed by a qualified health professional (e.g., physician, psychologist) to certify that you require the accommodation.

Examples of documentation completed by the qualified health professional that would support the accommodations request include:

- Identification of the disability and/or diagnosis;
- The approximate date when the disability was first diagnosed and/or identified;
- A brief history and description of the disability;
- Identification of the tests and/or protocols used to confirm the diagnosis;
- A description of past accommodations granted for the disability;
- The nature/type of the accommodation currently being requested;
- An explanation why the specific accommodation is needed;
- A legible signature, title and qualifications, and contact information (telephone, e-mail) of the qualified health professional; and
- History of accommodations provided to the candidate in testing situations during her/his education program.

Please submit the supporting documentation along with this form to the regulatory authority.

I have known _____ since _____
(name of candidate) (date)

in my capacity as a _____ . Due to the nature of the
(professional title)

candidate's disability _____ ,
(description of the candidate's disability)

it is my opinion that the candidate should be accommodated by providing the following: (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Separate room | <input type="checkbox"/> Use of voice output software | <input type="checkbox"/> Large print exam |
| <input type="checkbox"/> Reader | (e.g. Kurzweil) | <input type="checkbox"/> Large print answer sheet |
| <input type="checkbox"/> Recorder (who fills in answers) | | |
| <input type="checkbox"/> Additional time (please specify time needed) _____ | | |
| <input type="checkbox"/> Other (please specify) _____ | | |

Comments by the qualified health professional completing this form

Name: _____

Title: _____

Telephone: _____

E-mail: _____

Signature: _____

Date: _____