REQUEST FOR Testing ACCOMMODATIONS

Please complete this form so that accommodation for testing can be processed efficiently. The information provided and any documentation regarding the student’s disability and need for testing accommodations will be considered strictly confidential and will not be shared with any outside source without the student’s express written consent. Submit any documentation that confirms previous testing accommodations instead of completing the “Professional Documentation” portion of this form.

Student ID number: _____________________________ ____

Last Name: ____________________________________________

First Name: ____________________________________________

Address: _____________________________________________

City: __________________ State: _____ Zip Code: ___________

Daytime Phone Number: __________________ Fax: _____________

E-mail: ________________________________________________

Special Accommodations:

Please provide (check all that apply)

_____ Special seating or other physical accommodations

_____ Magnifying screen for examination

_____ Reader

_____ Extended testing time (normally 1.5 additional hours)

_____ Separate testing area

_____ Other special accommodations (please specify)

Signed: _____________________________________________ Date: __________________
DOCUMENTATION OF DISABILITY-RELATED NEEDS

Students who have a learning disability, a psychological disability, or other disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that the student’s disabling condition requires the requested test accommodation. Student may submit existing documentation of the same or similar accommodation provided during other testing situation instead of completing the “Professional Documentation” portion of this form.

Professional Documentation

I have known_________________________________________ since ______ / ______ / ____

Student’s name Date

in my capacity as a (n) _________________________________________________.

Professional Title

The student discussed with me the nature of the test to be administered. It is my opinion that because of this student’s disability accommodations should be provided.

Description of Disability:

Signed: ________________________________ Title: ________________________________

Printed Name: ________________________________

Address: ________________________________________________

Telephone Number: ________________________________

Date: _______________ License # (if applicable): _______________________________