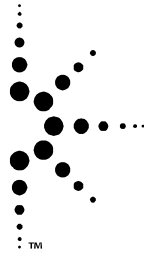


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PROMETRIC



# **ADA ACCOMMODATIONS REQUEST PACKET**

**After completing these forms please  
Fax to: 410-385-8504**

**OR**

**Mail To:  
Testing Accommodations  
7941 Corporate Drive  
Nottingham, MD 21236**

**Any questions or concerns please call:  
1-800-967-1139**

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Prometric strives to provide an equal testing opportunity for all candidates. The purpose of any testing accommodation is to ensure that the examination results reflect a candidate's aptitude or other factors that the exam is designed to measure, rather than reflecting the candidate's sensory, manual or psychological skills (except where those skills are factors the exam is designed to measure).

We ask all candidates requesting an accommodation to take the time to carefully complete this packet before submitting their request. A completed Accommodation Request Packet includes the Candidate Accommodation Request Form, the Professional Evaluation Form, and any additional information or documentation requested by Prometric and/or your Test Sponsor in order to evaluate an accommodation request. A complete packet will allow Prometric to assist the candidate in arranging the best accommodation possible for the situation. **We are unable to process incomplete accommodation requests.**

**Please note this application is valid for one (1) year from the approval date. If you wish to test with accommodations after your approval expiration date, you must resubmit a new application for processing.**

*Approved accommodations will be arranged as quickly as possible and at no extra charge to the candidate.*

Our Advocates are here to help you. Please contact us to answer any questions or concerns about who signs where, what type of accommodation would work best for you, or to simply walk you through the request process.

To help you in your request, Please keep the following in mind as you complete this packet:

1. All test sites are wheelchair accessible — No request for a wheelchair is required.
2. Generally, you **MUST** have an appropriately licensed professional (an internist, for example, is not appropriate to diagnose a mental disorder or reading disability) complete the Professional Evaluation Form. Any existing documentation that you have that will support your request can be helpful to us in evaluating your request. In limited situations existing documentation, such as a recent neuropsychological report, may be sufficient without the need for a licensed professional to complete the Professional Evaluation Form.
3. We can **NOT** make any accommodations of a “personal or physical nature” (lifting or feeding, for example). Personal assistants may help setup an individual to test, but are generally not permitted to stay with the candidate in the testing room. This does not include an accommodation request for a Reader or Recorder, which will be approved with the proper documentation.

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## CANDIDATE ACCOMMODATION REQUEST FORM

Candidate Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Other Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Name and Number of the Exam(s) Requested: \_\_\_\_\_

Exam Site Requested: \_\_\_\_\_

Earliest Date You Are Available to Test: \_\_\_\_\_

Describe your Disability: \_\_\_\_\_

**Additional Testing Time(Chose One)**

\_\_\_\_\_ *Thirty minutes*

\_\_\_\_\_ *50% (time and one-half)*

\_\_\_\_\_ *100% (double time)*

**Assistance**

\_\_\_\_\_ *Reader*

\_\_\_\_\_ *Recorder of answers*

\_\_\_\_\_ *Sign Language Interpreter*

(For spoken directions only)

\_\_\_\_\_ *Dragon Naturally Speaking*

\_\_\_\_\_ *JAWS*

\_\_\_\_\_ *Keyboard only*

Additional Comments (For example: "Will need to bring a nurse assistant."): \_\_\_\_\_

Some accommodations may require three weeks or longer. For example, if we are required by your test sponsor to have a government physician review your medical records, it could easily take over 3 weeks. Where additional time is requested, you must provide details as to the severity of the condition and an explanation as to why the candidate condition supports the request for additional time.

**PLEASE READ AND SIGN:**

I authorize release of the attached forms to Prometric staff to review and arrange the requested accommodation.

I give my permission for my diagnosing professional to discuss with Prometric staff my records and history in as much as they relate to the requested or suggested accommodation.

I understand and agree that Prometric staff may provide my records to an appropriate professional selected by Prometric for an independent evaluation relating to my request or to the organization or agency for which the exam is administered.

Candidate Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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# LICENSED PROFESSIONAL EVALUATION FORM

## *To Be Completed Only By A Licensed Professional*

To the Professional:

By submitting this form with your signature and license number listed, you are verifying that you have formally diagnosed the candidate named on this form as having the disability documented below or, in your professional capacity; you have worked with the candidate in dealing with the disability documented on the following page. You further verify that the accommodation you recommend is necessary to fairly demonstrate the candidate's ability in a licensure exam.

The purpose of any testing accommodation is to ensure that the examination results reflect a candidate's aptitude or other factor that the exam is designed to measure, rather than reflecting the candidate's sensory, manual or psychological skills (except where those skills are factors the exam is designed to measure). **Our intent is to provide equal opportunity for all candidates. The accommodation must not unfairly advantage or disadvantage the candidate.**

Please call us if you have any questions at 1-800-967-1139 regarding the exam or response format, physical environment, required documentation or determination of appropriate and reasonable accommodations. Finally, Prometric is unable to accommodate a request for "unlimited time." If extra time is needed, please specify the amount.

Exam Candidate Name: \_\_\_\_\_

Licensed Professional (Please Print your Name): \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-Mail: \_\_\_\_\_

License Number: \_\_\_\_\_ State of Licensure: \_\_\_\_\_

Board Certification: \_\_\_\_\_

Signature of Professional: \_\_\_\_\_ Date: \_\_\_\_\_

\* Candidate's diagnosis and your recommendation on back page (Attach additional pages if needed.)

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**LICENSED PROFESSIONAL EVALUATION**  
***To Be Completed Only By A Licensed Professional***

Exam Candidate Name: \_\_\_\_\_

Diagnosis: (Note: mental and emotional disabilities must include diagnosis code from DSM-III-R or DSM-IV.)

I have known \_\_\_\_\_ (*candidate*) since \_\_\_\_\_ (*date*) in my capacity as a \_\_\_\_\_. The candidate has been diagnosed with the following disability. Please provide historic details on the candidate's condition(s).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The candidate or Prometric staff has discussed with me the nature of the test to be administered. It is my opinion that because of the candidate's disability, the candidate should be accommodated by Prometric with the following accommodations. **(Please include explanation for the accommodation.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Licensed Professional: \_\_\_\_\_

Licensed Professional's Name (*printed*): \_\_\_\_\_

Licensed Professional's Title: \_\_\_\_\_