APPLICATION FOR TESTING ACCOMMODATIONS
SPECIAL ENROLLMENT EXAMINATION

Contains:
- Candidate Accommodation Request Form to be completed by the candidate
- Professional Evaluation Form to be completed by a licensed professional who has made the diagnosis or treated the candidate

Please Complete and return to Prometric
by Fax: 410-385-8504
by mail: Prometric Testing Accommodations
7941 Corporate Drive
Nottingham, MD 21236

Approval of 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.

Completed Accommodation Request Packets are generally reviewed within 5 to 7 business days and are kept confidential. If approved, accommodations will be arranged as quickly as possible and at no extra charge to you. Failure to complete both forms entirely may delay scheduling your exam.

Please contact us at 1-800-967-1139 to answer any questions or concerns, or to discuss the type of accommodation which would work best for you. Please keep the following in mind as you complete this packet:

1. All test centers are physically accessible to individuals with disabilities.
2. Generally, you must have an appropriate professional complete the Professional Evaluation Form. For example, a medical doctor would be an appropriate professional to request an accommodation with respect to diabetes but not with respect to a reading disability. If you have existing documentation of a disability or documentation where similar accommodations were provided, this documentation should be submitted along with the Professional Evaluation Form. In some cases, existing documentation may be sufficient to support an accommodation without necessitating the need for a professional to complete the Professional Evaluation Form.
3. Prometric cannot make any accommodations of a “personal nature” (lifting or feeding, for example). Personal assistants may help setup an individual to test but are not permitted to stay with the candidate in the testing room.
4. Prometric may request that you have the licensed professional provide your records or reports that support the need for an accommodation.
5. Requests for additional time are granted only in an interval of either 30 minutes, 50% additional time or 100% additional time.
TESTING ACCOMMODATION REQUEST FORM
(To be completed by testing candidate)

Name: ______________________________________________________________

PTIN: ________________________________

Address: ____________________________________________________________________________

City, State, Zip: ________________

Daytime Phone Number: ____________ Other Phone Number: ____________________________

Fax Number: __________________________ E-Mail: _______________________________

Test Center Location Requested: __________________________________________________________

Describe Your Disability: _______________________________________________________________

Check the accommodation(s) you are requesting:

<table>
<thead>
<tr>
<th>Additional Testing Time</th>
<th>Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>______ Thirty minutes</td>
<td>______ Keyboard only</td>
</tr>
<tr>
<td>______ 50% (time and one-half)</td>
<td>______ Dragon Naturally Speaking</td>
</tr>
<tr>
<td>______ 100% (double time)</td>
<td>______ JAWS</td>
</tr>
<tr>
<td></td>
<td>______ Reader</td>
</tr>
<tr>
<td></td>
<td>______ Recorder of answers</td>
</tr>
<tr>
<td></td>
<td>______ Sign Language Interpreter (for spoken directions only)</td>
</tr>
</tbody>
</table>

Additional accommodation requests or /comments (e.g. will need to bring a nurse assistant):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Some accommodations may take three weeks or longer to arrange.

Please read and sign:
• I understand and agree that Prometric staff will provide my records to the Internal Revenue Service.
• I hereby give my consent for Prometric or the Internal Revenue Service to discuss my medical condition with the individual who signed the below licensed professional evaluation form.

Testing candidate’s signature: ________________________________ Date: ______________
By submitting this form with your signature and license number, you are verifying that you have diagnosed and/or treated the candidate for the disability documented herein. 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. Prometric’s intent is to provide an equal testing opportunity for all candidates. The accommodation must not unfairly advantage the candidate. Please call us at 1-800-967-1139, Monday through Friday from 8:00 a.m. to 6:00 p.m. Eastern Time, if you have any questions.

Licensed Professional’s Name (Printed): ____________________________________________
Licensed Professional’s Address: ________________________________________________

Phone Number: __________________________ Fax Number: __________________________
E-Mail: ________________________________
Type of License: ______________________ License Number: ________________________
State of Licensure: _____________________ Board Certification: ______________________

Name of patient: _______________________________

**Diagnosis:** The testing candidate has been my patient since __________. The testing candidate has been diagnosed with the following disability. (Please print clearly and include details of the severity of the disability and why the accommodation is necessary. Include DSM diagnosis code for mental and emotional disabilities. (Attach additional pages if needed) __________________________________________________

**Accommodation requested:** Where additional time is requested provide an explanation as to why the candidate’s condition requires additional time. Requests for additional time can only be provided in increments of 30 minutes, 50% additional time or 100% additional time.

Check the accommodation the candidate needs:

<table>
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</table>

**List any other accommodations needed.** (Attach additional pages if needed)

____________________________________________________________________________________

____________________________________________________________________________________

Signature of Licensed Professional:

____________________________________________________________________________________