Documentation of Disability-Related Needs by Qualified Provider

This section must be completed by the test taker. Once you have checked the required special accommodation(s), please sign next to Application Signature. The second page must be completed by a licensed health care provider.

Please Select the Required Accommodation(s):

- Reader
- Reader and Recorder
- Sign Language Interpreter
- Screen Magnification software
- Private Room
- Food/Drink/Medical Equipment required during test session - (describe the specific items needed in the additional information section below)
- Attendance of Service Animal
- Extended Exam Time
- Other - (please describe in the additional information section below)

Additional information:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
______________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Applicant Signature: _______________________________________________
This section must be completed by a licensed health care provider. The nature of the disability, identification of the test(s) used to confirm the diagnosis, a description of past accommodations made for the disability, and the specific testing accommodations requested must be included.

**Professional Documentation**

I have known ___________________________ since ________ in my capacity as a(n) _________.

(Name of Applicant) (Date)

___________________________

(Professional Title) (Board Certification)

The applicant discussed with me the nature of the test being administered. It is my opinion that because of this applicant’s disability described below, he/she should be accommodated by providing the special arrangements listed on the Special Testing Accommodation Request Form.

Comments on Disability:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature: ________________________________

Title: ________________________________

Organization: ________________________________

License # (if applicable): ________________________________

Phone Number: ________________________________

Date: ________________________________

**Candidate Instructions:** Please submit your completed request via e-mail to emannle@iapp.org with the words: Accommodation Request in the subject line of the e-mail. Accommodation requests must be made at least 30 days in advance of the earliest requested testing date.