REQUEST FOR TESTING ACCOMMODATIONS

Instructions: Individuals with disabilities covered by the Americans with Disabilities Act must complete this form and have a qualified professional complete the **Documentation of Disability-Related Needs** form (next page) in order for their accommodations request to be processed.

Applicant Information

Full Name	
Address	
City, State, Zip, Country	
Telephone Number	
Email Address	

Past Testing Accommodations History

Have you previously received testing accommodations during any of the following? Mark the appropriate box.	**YES**	**NO**
Certification or Licensure Examination	☐	☐
Vocational Training or Higher Education	☐	☐
Elementary or Secondary School	☐	☐

For each "YES" response above, attach a detailed description of your accommodation history to this form. The description must include:

- The disability related to the accommodation;
- The accommodation provided;
- The organization providing the accommodation;
- The name of the examination for which the accommodation was provided; and
- The date that the examination and accommodation were provided. Also, if you took an exam multiple times, but did not receive accommodations for all administrations of the exam, please indicate

By signing below, I verify that the information provided on this form and attached documentation (if any) is complete and accurate to the best of my knowledge. I understand that I must submit this form and the Documentation of Disability-Related Needs Form at least 30 days prior to the exam in order for their accommodations request to be processed.

Candidate Signature: _____ Date: _____

Send to: NCSG Certification Manager
1255 SW Prairie Trail Parkway
Ankeny, Iowa 50023
-or-
jessica@ncsg.org

DOCUMENTATION OF DISABILITY-RELATED NEEDS BY QUALIFIED PROVIDER

This form must be completed by a qualified professional. A qualified professional is licensed or otherwise properly credentialed and possesses expertise in the disability for which an accommodation is sought. The qualified professional is a physician or other qualified professional who has individually assessed the disability of the candidate. The qualified professional must provide the required information concerning the disability and the requested accommodation. The information and any documentation that the candidate provides regarding their disability and the need for accommodation(s) will be treated as confidential.

Qualified Professional Information

Full Name	
Business Address	
City, State, Zip, Country	
Telephone Number	
Email Address	
Professional Title (e.g., Medical Doctor, Licensed Psychologist)	
License Number and State Issuing License	
Professional Certification and Organization Issuing Certification	

Description of Disability

Nature of the Disability Related to the Accommodations Request	
Recommendation for Accommodation by Qualified Professional	
The Reason for the Requested Accommodation	
History of Diagnosis and Results of Professional Evaluations	

The applicant discussed with me the nature of the course and tests being administered. It is my opinion that because of this applicant's disability described above, he/she should be accommodated by providing the special arrangements listed on the next page.

Requested Accommodations (Check all that you are requesting).

☐ Adjustable Font Size	☐ Noise Canceling Headphones
☐ Beverage	☐ Screen Magnifier
☐ Colored Screen Overlays	☐ Separate Room
☐ Earplugs	☐ Separate Room and May Move Around
☐ Extended Exam Time. How much? _____	☐ Separate Room and Reader
☐ Frequent/Extended Breaks	☐ Separate Room and Sign Language Interpreter
☐ Glucose Testing Supplies	☐ Separate Room and Snacks
☐ Other (please describe):	

By signing below, I verify that the information provided on this form and in the attached documentation (if any) is complete and accurate to the best of my knowledge.

Qualified Professional Signature: _____ Date: _____