REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by Americans with Disabilities Act as Amended (ADAAA), please complete this form and provide a letter from a licensed medical professional. You will upload both pages into your application at least 45 days prior to your requested examination date. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality.

Name (Last, First, Middle)

_____

Street Address

_____

_____

City State Zip Code/Postal Code Country

_____

Daytime Telephone Number Email Address

_____ _____

Special Accommodations

I request special accommodations for the following examination:

- ☐ CCTC
- ☐ CPTC
- ☐ CTP
- ☐ CCTN
- ☐ TFCA

Please provide (check all that apply):

_____ Reader

_____ Extended testing time (time and a half)

_____ Reduced distraction environment

_____ Other special accommodations (Please specify.)

_____

_____

_____

Comments:

_____

_____

PLEASE READ AND SIGN:

I give my permission for my diagnosing professional to discuss with PSI staff my records and history as they relate to the requested accommodation.

Signature: _____Date: _____