

Appendix F

Special Testing Accommodation Request Form

Candidates with disabilities covered by the Americans with Disabilities Act should complete this form and have an appropriate licensed professional complete the Documentation of Disability-Related Needs form so their requests for accommodations can be processed efficiently. The information provided and any documentation regarding the disability and the need for accommodation in testing will be treated with strict confidentiality.

CANDIDATE INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Primary Telephone Number: _____ ABPANC ID Number: _____

Examination Administration Window (online candidates)

Test Date (paper/pencil candidates)

SPECIAL TESTING ACCOMMODATIONS

Please check the accommodation(s) that you require: (Check all that apply.)

Wheelchair access

Special seating

Reader

Recorder/Scribe

Extended testing time

30 minutes extra time

time and a half

double time

Separate testing area

Zoom text font size (online candidates) or large font size (paper/pencil candidates)

Other special accommodations (please specify) _____

See the back of this page for the Documentation Form.

Please mail, email or fax this completed form to PES so that it is received within seven (7) business days of submitting your application.

Mail, email or fax the two forms found in Appendix F to:

Professional Examination Service

ABPANC Testing Office (032)

475 Riverside Drive, 6th Floor • New York, NY 10115 USA

Email: abpanc@proexam.org • Fax: 1-212-367-4343

Appendix F

Documentation Of Disability-Related Needs By Qualified Professional *(Continued)*

This section must be completed by a licensed health care provider or an educational or testing professional to ensure that PES is able to provide the required test accommodation.

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 accommodation requested must be included.

PROFESSIONAL DOCUMENTATION (Please Print Legibly)

I have known _____ since _____
(Name of Candidate) (Date)

In my capacity as a(n)

(Professional Title)

The candidate discussed with me the nature of the test to be administered. It is my opinion that, because of this candidate's disability described below, he or she should be accommodated by providing the special arrangements listed on the Special Testing Accommodation Request form.

Comments:

Print Name: _____

Signature: _____ Title: _____

Date: _____ License No. _____ State _____
(if applicable)

Street Address _____

City _____ State _____ Zipcode _____

Daytime Phone Number _____

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