

Pediatric Audiology Specialty Certification Application

FORM 5a: Request For Test Accommodations

If you have a disability covered by the Americans with Disabilities Act (ADA), please complete this form and *Form 5b: Documentation of Disability-Related Needs* so your accommodations for testing can be processed efficiently. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality.

Print Name: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Daytime Telephone Number: _____
Email: _____

Special Accommodations

I request special test accommodations for the _____ / _____ administration of the PASC Exam.
MONTH YEAR

Please provide (check all that apply):

- Reader
- Extended examination time (time and a half or double time)
- Frequent breaks
- Access to auxiliary items (food, medication, or medical devices)
- Other test accommodations (please specify)

Comments: _____

Signed: _____ Date: _____

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FORM 5b: Documentation of Disability-Related Needs

Please have the appropriate professional (doctor, psychologist, psychiatrist) complete this form to document the need for the requested test accommodation(s).

Professional Documentation

I have known _____

EXAM CANDIDATE (PRINT NAME)

in my capacity as a _____

PROFESSIONAL TITLE

since _____ / _____ / _____
MONTH DATE YEAR

The applicant discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability described below, he/she should be accommodated by providing the special test accommodations listed on the *Form 5a*.

Description of Disability: _____

Signed: _____

Title: _____

Print Name: _____

Address: _____

Telephone Number: _____ Date: _____

License # (if applicable): _____