TEST ACCOMMODATIONS REQUEST FORM INSTRUCTIONS

Purpose of this form

Professional Testing Corporation (PTC) provides reasonable testing accommodations to qualified individuals with disabilities in accordance with the Americans with Disabilities Act (ADA) and applicable law. Accommodation requests are reviewed individually based on the candidate's disability-related functional limitations and the testing accommodation requested.

When to submit your request

Candidates should submit accommodation requests as early as possible, preferably at least eight weeks before the beginning of the selected testing period, to allow adequate time for review and scheduling. Requests submitted later will be reviewed as required by applicable law. Late submission may affect PTC's ability to arrange an accommodation for the requested testing period.

What documentation should I submit?

Documentation should demonstrate:

- the existence of a disability;
- the disability-related functional limitation(s) affecting testing; and
- how the requested accommodation addresses those limitations.

Documentation may include, as appropriate:

- documentation of accommodations previously received on a similar standardized examination;
- a current or recent IEP or Section 504 Plan;
- documentation of accommodations received in college, graduate school, or another educational setting;
- an evaluation or documentation from an appropriately qualified professional; or
- other documentation supporting the disability-related need for the requested accommodation.

Previous accommodations

If you have previously received accommodations in an educational, licensing, certification, employment, or similar testing setting, please provide available documentation. PTC will give appropriate consideration to accommodations previously provided in similar testing situations.

When should Part II be completed?

Part II should be completed by a qualified health care or other appropriate professional when professional documentation is necessary to support the request. Part II may not be required when other documentation submitted by the candidate sufficiently establishes the disability-related need for the requested accommodation.

PROFESSIONAL TESTING CORPORATION

TEST ACCOMMODATIONS REQUEST FORM

PART I – CANDIDATE INFORMATION

[to be completed by the candidate]

Examination: _____

Test Period: _____

Name: _____

Address: _____

Email: _____

Phone: _____

1. **Have you previously received accommodations in an educational, licensing, certification, or employment setting?** ☐ Yes ☐ No

Year	Type of Accommodation(s)	Who Provided the Accommodation?

2. **If accommodations were provided in college, graduate school, or another testing program, please attach supporting documentation.**

3. **Requested Accommodations**

☐ Reader ☐ Scribe ☐ Separate Testing Room ☐ Extended Testing Time ☐ Other

If other, please describe:

I understand that my request for accommodations will be reviewed on an individualized basis. The accommodations approved by PTC may differ from those requested if the documentation submitted does not support all requested accommodations.

I give my permission for PTC to reach out to my Qualified Provider for clarification if needed.

Candidate Signature: _____

Date: _____

INSTRUCTIONS FOR THE QUALIFIED PROFESSIONAL

Thank you for assisting this candidate with a request for testing accommodation

Professional Testing Corporation (PTC) reviews requests for testing accommodations on an individualized basis. The purpose of Part II of this form is to help PTC understand the candidate's disability-related functional limitations in a testing environment and the accommodation(s) that appropriately address those limitations.

Please complete Part II based on your professional knowledge of the candidate and your independent professional judgment.

Information Requested

Please provide information regarding:

- The condition or impairment relevant to the candidate's accommodation request.
- The specific functional limitation(s) resulting from the condition.
- How those functional limitations affect the candidate when taking a timed examination.
- The testing accommodation(s) you recommend based on those functional limitations.
- The relationship between each recommended accommodation and the functional limitation it is intended to address.

A diagnosis alone does not determine a particular testing accommodation. Individuals with the same diagnosis may experience different functional limitations and may require different accommodations.

When describing functional limitations, please provide information relevant to the testing environment. Examples may include effects on:

- Reading speed
- Processing speed
- Sustaining attention or concentration
- Seeing or hearing
- Writing or recording responses
- Physical positioning or mobility
- Endurance or fatigue
- The need for medical monitoring, treatment, or disability-related breaks
- Other functions that affect the candidate's ability to take the examination

Recommended Accommodations

Please use your independent professional judgment when recommending testing accommodations. The accommodation you recommend **does not need to be the same accommodation requested by the candidate**. Please recommend the accommodation, or combination of accommodations, that you believe appropriately addresses the candidate's documented functional limitations.

For example, depending on the candidate's individual limitations, an appropriate accommodation may include extended testing time, additional or stop-the-clock breaks, a separate or reduced-distraction testing environment, a reader, a scribe, or another accommodation.

Please explain how each recommended accommodation addresses the functional limitation(s) identified in Part II.

Extended Testing Time

If extended testing time is requested, please recommend the amount of additional time that you believe is appropriate based on the candidate's individual functional limitations.

Your recommendation does not need to match the amount of additional time requested by the candidate.

When determining the amount of additional testing time, please consider factors such as:

- The degree to which the candidate's disability affects reading or processing speed
- The effect of the disability on the candidate's ability to sustain attention
- The amount of additional time needed to compensate for disability-related interruptions
- Fatigue or endurance associated with the candidate's disability
- Whether breaks or another accommodation may more directly address the identified limitation
- The length of the examination

Please consider the total examination duration when making your recommendation. For example, **100% additional time on a four-hour examination permits up to eight hours of testing**. The amount of additional time recommended should reflect the candidate's disability-related functional limitations and testing needs rather than simply the maximum amount of time that could be provided.

If you recommend more than 50% additional testing time, please explain the functional limitation(s) supporting that recommendation and why a lesser amount of additional time would not adequately address those limitations.

Provider Certification

By completing and signing Part II, you are confirming that:

- You are licensed and qualified to evaluate and/or treat the condition described.
- You have personal knowledge of the candidate's condition.
- The information you provide is accurate to the best of your knowledge.
- Your accommodation recommendations reflect your independent professional judgment based on the candidate's functional limitations.

PTC is responsible for determining the testing accommodations that will be approved. Your role is to provide information regarding the candidate's condition, functional limitations, and the accommodation(s) you recommend based on those limitations.

PART II – To Be Completed by the Qualified Provider

The provider completing this form must be licensed and qualified to diagnose and/or treat the condition described below and must have personal knowledge of the candidate's condition.

Provider Name: _____

Professional Title: _____

License Number: _____

State of Licensure: _____

Date(s) of Evaluation: _____

A. DIAGNOSIS

Diagnosis:
ICD/DSM Code (if applicable):
Date of Onset:

B. FUNCTIONAL LIMITATIONS

Identify and explain each specific functional limitation that affects the candidate's ability to take a timed examination.

Check all that apply and explain as appropriate:

- ☐ Reduced reading speed
- ☐ Reduced processing speed
- ☐ Difficulty sustaining attention/concentration
- ☐ Difficulty writing or recording responses
- ☐ Need for medical monitoring or treatment
- ☐ Visual impairment
- ☐ Hearing impairment
- ☐ Mobility impairment
- ☐ Other

Description of functional limitations:
Major life activities affected:

C. RECOMMENDED ACCOMMODATIONS

Please identify the testing accommodation(s) you recommend based on the candidate's disability-related functional limitations and explain how each recommended accommodation addresses those limitations in the testing environment.

Accommodations Requested:
Clinical Rationale:

D. EXTENDED TIME REQUESTS

Please recommend the amount of additional time that you believe is appropriate based on the candidate's functional limitations.

Please see the Provider Instructions for more guidance.

Amount of Additional Time Recommended:

☐ 25% ☐ 50% (time and a half) ☐ 100% (double time) ☐ Other: _____%

Please explain how the candidate's functional limitations affect the amount of time needed to complete a timed examination and why the amount recommended above is appropriate.
If more than 50% additional testing time is requested, please explain why 50% additional time would be insufficient.

PROVIDER CERTIFICATION

I have evaluated _____ on ____/____/____.

I certify that I am qualified to evaluate the condition(s) described above and that the information provided is accurate to the best of my knowledge.

I have discussed the type and nature of the examination to be administered with the candidate. It is my professional opinion that due to the diagnosis and functional limitations the candidate experiences as described above, he or she should be provided with the testing accommodations indicated.

Provider Signature: _____

Date: _____

Phone: _____

Email: _____

Candidates should upload pages 2, 5, 6, & 7 of this form to the examination application at least 8 weeks prior to the start of your chosen testing window. Missing or incomplete pages can cause delays in processing your accommodations request.

https://apply.ptcny.com