

REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by the Americans with Disabilities Act, please complete this form and the Documentation of Disability-Related Needs on the next page 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. Please return this form to AMP within 45 days of the desired testing date.

CANDIDATE INFORMATION

Name (Last or Family Name, First, Middle Initial, Former Name)

Mailing Address

City State/Province Zip Code/Postal Code and Country

Daytime Telephone Number with country code if outside of North America

SPECIAL ACCOMMODATIONS

I request special accommodations for the _____ examination.

Please provide (check all that apply):

- Reader
- Extended examination time (time and a half)
- Reduced distraction environment
- Large print examination (paper and pencil administration only)
- Circle answers in examination booklet (paper and pencil administration only)
- Other special accommodations (Please specify.)

Comments: _____

PLEASE READ AND SIGN:

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

Signature: _____ Date: _____

Return this form with your examination application and fee to:
Examination Services Department, AMP, 18000 W. 105th Street, Olathe, KS 66061-7543, Fax (913) 895-4650.
If you have questions, call the Examination Services Department at (888) 519-9901.

DOCUMENTATION OF DISABILITY-RELATED NEEDS

Please have this section completed by an appropriate professional (education professional, physician, psychologist, psychiatrist) to ensure that AMP is able to provide the required examination accommodations.

PROFESSIONAL DOCUMENTATION

I have known _____ since ____/____/____ in my capacity as a
Candidate Name Date (month/date/year)

Professional Title

The candidate discussed with me the nature of the examination to be administered. It is my opinion that, because of this candidate's disability described below, he/she should be accommodated by providing the special arrangements listed on the reverse side.

Description of Disability: _____

Signed: _____ Title: _____

Printed Name: _____

Address: _____

Telephone Number: _____

Date: _____ License # (if applicable): _____

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