REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by the Americans with Disabilities Act, **please complete this form and provide the Documentation of Disability-Related Needs on the next page and submit it with 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.

Candidate Information

Candidate ID # _____ Requested Test Center:_____

_____
Name (Last, First, Middle Initial, Former Name)

_____
Mailing Address

_____

_____
City State Zip Code

_____
Daytime Telephone Number Email Address

Special Accommodations

I request special accommodations for the _____ examination.

Please provide (check all that apply):

_____ Reader
_____ Extended testing time (time and a half)
_____ Reduced distraction environment
_____ Please specify below if other special accommodations are needed.

_____
_____
_____

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:_____

Return this form to:
PSI, 18000 W. 105th St., Olathe, KS 66061-7543
If you have questions, call Candidate Services at 800-345-6559.

DOCUMENTATION OF DISABILITY-RELATED NEEDS

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

Professional Documentation

I have known _____ since _____ / _____ / _____ in my capacity as a
Candidate Name Date

_____.
My 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/she should be accommodated by providing the special arrangements listed on the Request for Special Examination Accommodations form.

Description of Disability: _____

_____

_____

_____

_____

Signed:_____ Title:_____

Printed Name: _____

Address:_____

_____

Telephone Number:_____ Email Address: _____

Date: _____ License # (if applicable): _____

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