



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 reverse side 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.

Candidate Information

Social Security # _____ - _____ - _____ Requested Assessment Center: _____

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

Mailing Address

City State Zip Code

Daytime Telephone Number

Special Accommodations

I request special accommodations for the _____ examination.

Please provide (check all that apply):

- Special seating or other physical accommodations
- Reader
- Extended testing time (time and a half)
- Distraction-free room
- Other special accommodations (Please specify.)

Comments: _____

Signed: _____ Date: _____

Return this form with your examination application and fee to:
Candidate Support Center, AMP, 18000 W. 105th Street, Olathe, KS 66061-7543.
If you have questions, call AMP at 913/895-4600.



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
Examination Candidate Date

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: _____ E-mail Address: _____

Date: _____ License # (if applicable): _____

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