

## TESTING ACCOMMODATIONS REQUEST FORM

If you have a disability and may require a special accommodation in taking any examination required for licensure or certification, be sure to complete and submit this form along with your application.

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written consent.

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of your Disability: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Accommodation(s) requested for the \_\_\_\_\_ examination.

Accommodation(s) requested (check all that apply):

- \_\_\_\_\_ Accessible Testing Site
- \_\_\_\_\_ Braille \_\_\_\_\_ Large Print \_\_\_\_\_ Tape
- \_\_\_\_\_ Reader as accommodation for visual impairment
- \_\_\_\_\_ Scribe-amanuensis as accommodation for visual or motor impairment
- \_\_\_\_\_ Reader as accommodation for learning disability
- \_\_\_\_\_ Scribe-amanuensis as accommodation for learning disability
- \_\_\_\_\_ Sign language interpreter
- \_\_\_\_\_ Extended Time
  - \_\_\_\_\_ Time-and-a-half \_\_\_\_\_ Double Time
  - \_\_\_\_\_ More than double time (specify): \_\_\_\_\_
- \_\_\_\_\_ Separate testing area
- \_\_\_\_\_ Use of computer or other adaptive equipment (specify): \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_

Comments: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Some accommodation requests may require additional documentation.  
Please see reverse side.

## DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist, etc.) to certify that your disabling condition requires the requested test accommodation. Documentation also needs to be submitted to support the diagnosis from the appropriate professional and the reason the requested accommodation(s) is/are necessary.

I have known \_\_\_\_\_ since \_\_\_\_\_ in my capacity as a  
(test applicant) (date)  
\_\_\_\_\_  
(professional title)

Nature of the applicant's disability \_\_\_\_\_

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by the following (check all that apply):

- \_\_\_\_\_ Taped exam
- \_\_\_\_\_ Large print test
- \_\_\_\_\_ Reader
- \_\_\_\_\_ Scribe-amanuensis
- \_\_\_\_\_ Extended time:
  - \_\_\_\_\_ Time-and-a-half
  - \_\_\_\_\_ Double Time
  - \_\_\_\_\_ More than double time (please justify)
- \_\_\_\_\_ Separate testing area
- \_\_\_\_\_ Use of computer or other adaptive equipment (please specify)
- \_\_\_\_\_ Other (please specify)

Printed Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ License # (if applicable): \_\_\_\_\_

Please fill both forms out completely and return to:

Indiana Professional Licensing Agency  
Attn: Physical Therapy Committee  
402 West Washington Street, Room W072  
Indianapolis, IN 46204