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 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 Assessment 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 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, AMP, 18000 W. 105th St., Olathe, KS 66061-7543
If you have questions, call the Candidate Support Center at 888-519-9901.
Please have this section completed by an appropriate professional (education professional, physician, psychologist, psychiatrist) to ensure that AMP 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 reverse side.

Description of Disability: ____________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Signed:____________________________________________________  Title: ____________________________________

Printed Name: _______________________________________________________________________________________

Address:____________________________________________________________________________________________

___________________________________________________________________________________________________

Telephone Number: _____________________________ Email Address: ________________________________________

Date: ________________________________________  License # (if applicable): _______________________________

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