

REQUEST FOR EXAM SPECIAL ACCOMMODATIONS

If you have a disability covered by the Americans with Disabilities Act or the Canadian Human Rights Act, please complete this form and the Documentation of Disability-Related Needs 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 ATD CI by uploading it to your application. This **MUST** be included as part of your exam application.

CANDIDATE INFORMATION

Full Legal Name:

Mailing Address:

City:

State/Province:

Postal Code:

Country:

Email:

SPECIAL ACCOMMODATIONS REQUESTED

I request special accommodations for my

APTD exam

CPTD exam

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 ATD CI staff my records and history as they relate to the requested accommodation.

Signature:

Date:

Upload this form as part of your ATD CI application for certification. If you have questions, please contact the ATD CI team at: certification@td.org

**DOCUMENTATION OF
DISABILITY-RELATED NEEDS**

Please have this section completed by an appropriate professional (education professional, physician, psychologist, or psychiatrist) to ensure that ATD CI is able to provide the required examination accommodations. *Alternatively*, you can upload a copy of documentation from an appropriate profession **which includes all of the below details.**

PROFESSIONAL DOCUMENTATION

I have known (candidate name) _____ since (date)

in my capacity as a (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, they should be accommodated by providing the special arrangements indicated above.

Description of Disability:

Recommended Accommodations:

Signature:

Title:

Printed Name:

Telephone:

Date:

License # (if applicable):

Licensing Authority:

Upload this form as part of your ATD CI application for certification. If you have questions, please contact the ATD CI team: certification@td.org