



## 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 PSI/AMP staff my records and history as they relate to the requested accommodation.

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

**Return this form to:**  
**PSI/AMP, 18000 W. 105th St., Olathe, KS 66061-7543**  
**If you have questions, call Candidate Services at 888-519-9901.**



## DOCUMENTATION OF DISABILITY-RELATED NEEDS

Please have this section completed by an appropriate professional (education professional, physician, psychologist, psychiatrist) to ensure that PSI/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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