



TESTING ACCOMMODATION REQUEST FORM

State Form 57177 (10-22)

PROFESSIONAL LICENSING AGENCY

If you have a disability and may require accommodations taking any examination required for licensure, certification, or registration, be sure to fill out and submit this form along with your application.

* This agency is requesting disclosure of Social Security numbers in accordance with IC 4-1-8-1; disclosure is mandatory, and this record cannot be processed without it.

**This agency is requesting confidential information in accordance with IC 25-1-5-11.

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 permission.

Name (first, last)

Profession on Application

Telephone Number
()

Social Security Number *

Applicant Number

Nature of your disability

Accommodations requested for the _____ examination (check all that apply):

- Braille
- Taped Test
- Large Print
- 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

Signature

Date (month, day, year)

Some accommodation requests may require additional documentation (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 (clinical mental health professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another recent test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in my capacity as a _____.
(test applicant) (date mm / dd / yyyy) (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, they should be accommodated by providing the following *(check all that apply)*:

- Braille
- Taped Test
- Large Print
- 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)*: _____

Healthcare Provider Printed Name and Credentials

Signature

Date *(month, day, year)*

Healthcare Provider's License Number *(if applicable)*