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): _____

Return this form to:
PSI/AMP, 18000 W. 105th St., Olathe, KS 66061-7543, Fax: 913-895-4650
If you have questions, call Candidate Services at 800-345-6559.

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:
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