TEST ACCOMMODATIONS REQUEST FORM

Complete all information and sign the release statement at the end of this section. Make sure all sections are complete before submitting the form. CCSWFL will review your documentation and let you know if any additional information is required.

DCF Student ID#: _____ Phone Number: _____

First Name: _____ Last Name: _____

Date of Birth: _____ E-Mail: _____

Release of Information: I grant permission to school officials and my healthcare provider(s) to release my education-related records and/or my medical or psychological records to CCSWFL and its designee solely for the purpose of reviewing my request for testing accommodations.

Candidate's Signature: _____

Date: _____

Part 1. Accommodations – Please indicate the testing accommodation(s) you are requesting (these accommodations should be in accordance with the professional diagnostician's recommendations):

- ☐ Extended time (specify how much extra time): _____
  Reason: _____
- ☐ Computer with natural reader program
  Reason: _____
- ☐ Reader*
  Reason: _____
- ☐ Large-print exam (Specify the font size): _____
  Reason: _____
- ☐ Private Room
  Reason: _____

Continue next page

- ☐ Small group setting
  Reason: _____
- ☐ Sign Language Interpreter
  Reason: _____
- ☐ Written instructions
  Reason: _____
- ☐ Other (specify): _____
  Reason: _____

***Note:** These accommodations are automatically approved with a private room to prevent distractions to other test-takers.

Part 2. Evaluation Timeline Criteria – The evaluation must be completed by a qualified professional within the specific timeframe as specified below:

Physical Disabilities & Chronic Health Conditions:
No more than **2 years** prior to the anticipated date of the exam
Psychological & Psychiatric Disorders:
No more than **2 years** prior to the anticipated date of the exam
Attention-Deficit/Hyperactivity Disorder:
No more than **5 years** prior to the anticipated date of the exam
Learning and Other Cognitive Disorders:
No more than **5 years** prior to the anticipated date of the exam

Part 3. Supporting Documentation – Please attached or promptly provide documentation from an appropriate professional diagnostician describing your functional limitations & specifying the medical condition causing functional limitations for testing situations.

Documentation **must** include:

- ☐ The date(s) of the assessment by the qualified professional
- ☐ Be printed on the evaluator's letterhead
- ☐ Be signed by the professional
- ☐ Be within appropriate timeframe (see above)
- ☐ Include the specific diagnosis of the disability, with a description of the candidate's limitations due to the disability
- ☐ Confirm that the symptoms are not due to other conditions, such as an emotional disorder, physical disorder, English-as-a second-language (ESL) factors, or lack of appropriate instruction
- ☐ A summary of the complete evaluation with the **recommended testing accommodations**

Submit this form to the CCSWFL along with a copy of the official medical documentation of your ADA requirements to: **patriciag@ccswfl.org** **OR FAX ATTN: PATRICIA GUTH 239-278-3031**

CCSWFL's Decision

- ☐ Request is **granted** as specifically requested
- ☐ Request is **granted** but different from original request _____

  _____
- ☐ Request is **denied** Reason: _____

  _____

  _____

CCSWFL Staff Signature: _____ Date: _____

Contact the Training Coordinator Patricia Guth at 239-278-0160 to schedule your appointment/s.

If Your Request is Denied
Review the explanation of the denial.